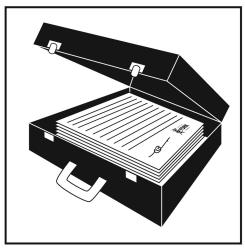
CITY OF YORK COUNCIL



Notice of meeting of

Executive Members for Housing & Adult Social Services and Advisory Panel

To: Councillors Greenwood (Chair), Sue Galloway (Executive Member), Sunderland (Executive Member), Fairclough, Nimmo, Fraser, Horton, Hill, Mrs Mildred Grundy (Co-opted Non-Statutory Member) and Ms Pat Holmes (Co-opted Non-Statutory Member)

Date: Monday, 15 January 2007

Time: 5.00 pm

Venue: The Guildhall

AGENDA

Notice to Members - Calling In:

Members are reminded that, should they wish to call in any item on this agenda, notice must be given to Democracy Support Group by:

10:00 am on Friday 12 January 2007, if an item is called in *before* a decision is taken, *or*

4:00 pm on Wednesday 17 January 2007, if an item is called in *after* a decision has been taken.

Items called in will be considered by the Scrutiny Management Committee.

1. Declarations of Interest

At this point Members are asked to declare any personal or prejudicial interests they may have in the business on this agenda.

2. Minutes (Pages 1 - 12)

To approve and sign the minutes of the meeting held on 11 December 2006.

3. Public Participation

At this point in the meeting members of the public who have registered their wish to speak regarding an item on the agenda or an issue within the Panel's remit can do so. Anyone who wishes to register or requires further information is requested to contact the Democracy Officer on the contact details listed at the foot of this agenda. The deadline for registering is Friday 12 January 2007 at 10.00am.

BUSINESS FOR THE EXECUTIVE MEMBER FOR HOUSING

ITEMS FOR DECISION

4. Rechargeable Repairs (Pages 13 - 18)

This report asks the Executive Member to approve a new approach to the recovery of rechargeable repairs.

5. Proposal to Designate Acomb Wood & Acomb Meadow as a Statutory Local Nature Reserve (Pages 19 - 26)

This report proposes that Acomb Wood and Acomb Meadow be declared a Local Nature Reserve as part of the development of a city wide network of Local Nature Reserves. As parts of the site are in differing Executive portfolios the report is presented to both the Executive Members for Housing and Leisure and Culture for approval.

ITEM FOR INFORMATION

6. Results of the 2006 Annual Housing Service Monitor (Pages 27 - 48)

This report provides the Executive Member with the headline results of the 2006 Annual Housing Service Monitor and will be supplemented by a presentation to Members at the meeting.

BUSINESS FOR THE EXECUTIVE MEMBER FOR ADULT SOCIAL SERVICES

ITEMS FOR DECISION

7. Long Term Commissioning Strategy for Older People in York (Pages 49 - 122)

This report informs Members of the development of a long term commissioning strategy for older people and seeks agreement to the framework for the development and delivery of this strategy. Members will receive a short presentation on the details contained in the Annexes to the report.

[Please note that the City of York Council Draft Long Term Commissioning Strategy for Older People - Annexes 1, 2 and 3 are available to view on the Council's website http://democracy.york.gov.uk/uuCoverPage.asp?bcr=1
Copies are available, if required, from Democratic Services – contact details at the foot of the agenda)]

8. Review of Non Residential Charging Policy (Pages 123 - 144)

This report recommends that the Executive Member agrees an updated charging policy for non residential care services subject to approval of the 2007/08 budget by the Executive in January.

ITEM FOR INFORMATION

9. Approval of proposals for implementation of the Mental Capacity Act (Pages 145 - 158)

This report informs the Executive Member of action that has been taken and is required to implement the Mental Capacity Act 2005.

10. Any other business which the Chair considers urgent under the Local Government Act 1972

Democracy Officer:

Name: Tracy Johnson
Contact details:
- Telephone – (01904) 551031
- E-mail – tracy.johnson@york.gov.uk

For more information about any of the following please contact the Democracy Officer responsible for servicing this meeting:

- Registering to speak
- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details are set out above.

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- register by contacting the Democracy Officer (whose name and contact details can be found on the agenda for the meeting) **no later than** 10.00 am on the last working day before the meeting;
- ensure that what you want to say speak relates to an item of business on the agenda or an issue which the committee has power to consider (speak to the Democracy Officer for advice on this);
- find out about the rules for public speaking from the Democracy Officer.

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Further information about what's being discussed at this meeting
All the reports which Members will be considering are available for viewing online on the Council's website. Alternatively, copies of individual reports or the full agenda are available from Democratic Services. Contact the Democracy Officer whose name and contact details are given on the agenda for the meeting. **Please note a small charge may be made for full copies of the agenda requested to cover administration costs.**

Access Arrangements
We will make every effort to make the meeting accessible to you. The meeting will usually be held in a wheelchair accessible venue with an induction hearing loop. We can provide the agenda or reports in large print, electronically (computer disk or by email), in Braille or on audio tape. Some formats will take longer than others so please give as much notice as possible (at least 48 hours for Braille or audio tape).

If you have any further access requirements such as parking close by or a sign language interpreter then please let us know. Contact the Democracy Officer whose name and contact details are given on the order of business for the meeting.

Every effort will also be made to make information available in another language, either by providing translated information or an interpreter providing sufficient advance notice is given. Telephone York (01904) 613161 for this service.

যদি যথেষ্ট আগে থেকে জানানো হয় তাহলে অন্য কোন ভাষাতে তথ্য জানানোর জন্য সব ধরণের চেষ্টা করা হবে, এর জন্য দরকার হলে তথ্য অনুবাদ করে দেয়া হবে অথবা একজন দোভাষী সরবরাহ করা হবে। টেলিফোন নম্বর (01904) 613161.

Yeteri kadar önceden haber verilmesi koşuluyla, bilgilerin tercümesini hazırlatmak ya da bir tercüman bulmak için mümkün olan herşey yapılacaktır. Tel. (01904) 613161.

我們竭力使提供的資訊備有不同語言版本，在有充足時間提前通知的情況下會安排筆譯或口譯服務。 電話(01904) 613161。

کسی بھی دوسری زبان میں معلومات کی دستیابی ترجمہ شدہ معلومات، ترجمان کی شکل میں یقینی بنانے کے لئے ہر ممکن کوشش کی جائے گی، بشرطیکہ اس کے لئے پہلے سے منا سب اطلاع کی جائے۔ ٹیلی فون 613161 (01904)

Holding the Executive to Account

The majority of councillors are not appointed to the Executive (38 out of 47). Any 3 non-Executive councillors can 'call-in' an item of business from a published Executive (or Executive Member Advisory Panel (EMAP)) agenda. The Executive will still discuss the 'called in' business on the published date and will set out its views for consideration by a specially convened Scrutiny Management Committee (SMC). That SMC meeting will then make its recommendations to the next scheduled Executive meeting in the following week, where a final decision on the 'called-in' business will be made.

Scrutiny Committees

The purpose of all scrutiny and ad-hoc scrutiny committees appointed by the Council is to:

- Monitor the performance and effectiveness of services;
- Review existing policies and assist in the development of new ones, as necessary; and
- Monitor best value continuous service improvement plans

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- Councillors get copies of all agenda and reports for the committees to which they are appointed by the Council;
- Relevant Council Officers get copies of relevant agenda and reports for the committees which they report to; and
- Public libraries get copies of **all** public agenda/reports.

City of York Council	Minutes
MEETING	EXECUTIVE MEMBERS FOR HOUSING & ADULT SOCIAL SERVICES AND ADVISORY PANEL
DATE	11 DECEMBER 2006
PRESENT	COUNCILLORS GREENWOOD (CHAIR), SUE GALLOWAY (EXECUTIVE MEMBER), SUNDERLAND (EXECUTIVE MEMBER), NIMMO, LIVESLEY (SUBSTITUTE), FRASER, HORTON, MRS MILDRED GRUNDY (CO-OPTED NON-STATUTORY MEMBER) AND MS PAT HOLMES (CO-OPTED NON-STATUTORY MEMBER)
APOLOGIES	COUNCILLORS FAIRCLOUGH AND HILL

48. Declarations of Interest

Members were invited to declare at this point in the meeting any personal or prejudicial interests they might have in the business on the agenda.

Cllr Fraser declared a general personal non prejudicial interest in relation to any HR implications in all the budget proposals as a retired member of Unison.

49. Minutes

RESOLVED: That the minutes of the last meeting held on 30 October 2006 be approved and signed as a correct record.

50. Public Participation

It was reported that there had been one registration to speak under the Council's Public Participation scheme.

Liz Young, Unison, addressed the committee on Agenda Item 12 (Service Plans and Revenue Budget estimates 2007/08). She raised concerns about the recommended savings proposal, contained in Annex 3, to combine Hew Horizons and Community Base, stating that the merger would reduce the number of places available and result in some staff being redeployed. She also highlighted concerns about the need to find £30 000 of savings, and that only £10 000 had been saved so far and it was feared that the other £20 000 could not be achieved without cutting jobs.

51. Housing Revenue Account Service Plan and Budgets 2007/2008

Members considered a report which advised of the revenue estimates for the Housing Revenue Account (HRA) for the financial year 2007/2008. Annex 1 provided a detailed analysis of the HRA's proposed budget.

The report advised that the result of all the variations outlined in paragraphs 17 - 22 was an in-year surplus of £1,530k. The brought forward working balance of £4,835k from 2006/07 was to be used to make a revenue contribution to capital schemes of £912k. The remainder brought forward of £3,923k together with the in year surplus of £1,530k leaves a working balance of £5,453k on the account. The HRA surplus was broadly in line with that forecast in the HRA business plan. It was therefore suggested that the HRA surplus, after using £912k as a revenue contribution, remained on the account to be reviewed once the HRA business plan was updated to reflect both the budget detailed in this report and the 06/07 outturn position. Members were reminded that the HRA surplus was needed to fund future years in line with the Business Plan approved at Housing EMAP in July 2005.

It was highlighted that due to the removal of the payment of rent rebates through the HRA there was now a net surplus on the 'notional HRA' as the rent income now exceeded the subsidy payable by the government for HRA expenditure on management and maintenance etc. This resulted in a 'negative' subsidy payable by the authority to the government of £5,354k for 2007/08. This compared to £4,902k for 2006/07.

Members queried about why the negative subsidy went back to the government. Officers explained that all local authorities had to have a HRA assessment on the number and type of properties to work out how much income the local authority should make. If the local authority makes more than this, then the negative subsidy had to go back to the government.

The Labour Group reserved their position.

Advice of the Advisory Panel

That the Executive member for Housing be advised to consider the budget proposals for Housing Revenue Account for 2007/08 contained in this report and listed below, and provide comments to be submitted to the Budget Executive on 16 January 2007.

- 2007/2008 Estimate as set out in paragraphs 17 – 20 and Annex 1.
- Growth proposals as set out in paragraph 21.
- Savings / additional income proposals as set out in paragraph 22.
- The brought forward surplus of £4,835k be included within next financial year to be used as outlined in paragraphs 24 -25.

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To ensure a balanced 2007/08 HRA budget is submitted to the Executive.

52. Housing General Fund Service Plan and Budget 2007/08

Members considered a report which presented the 2007/08 budget proposals for Housing General Fund. It included the budget for 2006/07 to show the existing budgets, the budget adjusted and rolled forward from 2006/07, the allocation of pay and price increases for the portfolio, budget service pressure proposals and savings options for the portfolio area, and budget options subject to consultation.

A summary of the budget proposals were contained in Table 1 under paragraph 8. Members were asked for their comments on the budget proposals in the report or alternative suggestions on the investment and savings proposals shown in Annexes 2 and 3.

The Labour Group reserved their position.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to

(i) Provide comments on the budget proposals for consultation for 2007/08 contained in this report, which will be considered by the Budget Executive on 16 January 2007.

(ii) Consider the budget proposals for consultation for Housing General Fund for 2007/08 contained in this report and listed below and provide comments to be submitted to the Budget Executive on 16 January 2007.

- 2007/08 Base budget as set out in paragraph 9;
- Service Pressure proposals as set out in Annex 2;
- Savings proposals as set out in Annex 3

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To ensure a balanced 2007/08 budget is presented to the Executive.

53. Review of Housing Fees and Charges

Members considered a report which recommended a revision of fees and charges, which fall within the Housing portfolio.

The report advised that as reported in the 'Housing Rents and Management and Maintenance Allowances 2007/08' the recommended average rent increase for 2007/08 was 5%. Other Housing Revenue

Account fees and charges had been reviewed to include a 5% uplift for accommodation and 2.3% (inflation) for other fees and charges.

Members were presented with two options:

Option 1 – To agree the charges as set out in the report.
Option 2 – To not accept the charges.

The outcome of the proposed changes would be increased income of £19k to the HRA and a reduction in income of £12k to Housing General Fund.

The Labour Group reserved their position.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to consider the proposals for the 2007/08 Housing fees and charges contained in this report and provide comments to be submitted to the Budget Executive on 16th January 2007.

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To ensure a balanced 2007/08 HRA budget is submitted to the Executive.

54. Housing Rents And Management And Maintenance Allowance 2007/08

Members received a report which asked the Executive Member to consider the rent guidelines and the management and maintenance allowances issued by the Department for Communities and Local Government (DCLG) for 2007/08.

Members were presented with three options:-

Option 1
In order to reduce the rent increase to within the DCLG limit of 5% a flat rate reduction across all council dwelling rents could be applied which would reduce each individual property rent by £0.45 per week and reduce the average increase to 5%. The Housing Revenue Account (HRA) would not lose any income by reducing the average increase from 5.82% to 5% as the reduction in increase from 5.82% to 5% would be compensated for by the DCLG through the rental constraint allowance, which forms part of the housing subsidy calculation.

Option 2 – RECOMMENDED OPTION
In order to reduce the rent increase to within the DCLG limit of 5% a reduction of £1.17 could be applied to bedsits and 1 bed flats. Both of these dwelling types are more difficult to let. Of 597 relets in 05/06 60% were bedsits or 1 bed flats therefore applying the rent reduction in these

areas may make them easier to let and whilst they were void the rent loss would be reduced.

Option 3
To ignore DCLG recommendations and increase council dwelling rents by 5.82%. This option would not generate any additional income for the HRA and would be difficult to justify as the reduction in increase from 5.82% to 5% outlined in options 1 and 2 would be compensated for by the DCLG through the rental constraint allowance as part of the Housing subsidy calculation.

The Labour Group reserved their position.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to approve option 2 and the rent increase in York of 5% be referred to Executive for approval.

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To enable a balanced HRA and comply with rent restructuring policy.

55. Housing Revenue Account Business Plan

Members considered a report which sought approval of the Revised Housing Revenue Account Business Plan 2006/7-2008/9.

Two options were presented to Members:

Option 1 – To approve the Business Plan.
Option 2 – To ask for changes to the Business Plan.

The Business Plan set out the detailed financial plan for investment in council homes to ensure all achieve the decent homes standard by 2010. At present approximately 1,034 (13% of all council homes) did not meet the standard currently. The business plan sets out the timetable and investment profile to ensure that zero non-decent homes would be achieved by 2010/11. This was a key government objective and a priority in the Council's Corporate Strategy 2006-9.

It was queried whether in the capital summary under paragraph 17, the £1912k expenditure on assistance to older and disabled people included the increase of £50k for adaptations. Officers reported that the £1912k did include the £50k increase for adaptations.

Members thanked staff for producing a document that was easy to read and informative.

The Labour Group reserved their position.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to approve the business plan (Option 1).

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: A thorough review of the plan took place in consultation with members, residents and Government office in 2005, and this year's plan represents only minor amendments to the existing plan projections and an update on progress.

56. Second Review of the 2006/07 Housing Capital Programme and programme for 2007/08 to 2010/11

Members considered a report which presented the second quarter review of the 2006/07 Housing Capital Programme, the resources available to support it and recommended that the Executive Member approved the variations. The report also included the proposed capital programme for 2007/08 to 2010/11.

The Approved Housing Capital Programme for 2006/07 was £10,046. The outcome of the minor variations agreed within officers' delegated authority and the variations outlined in the report result in a £5k decrease in position hence the Programme for 06/07 would stand at £10,041k with £4,581k funded through the MRA. The proposed programme for 2007/08 to 2010/11 attached at annex 2 was fully funded from ring fenced housing resources including the Major Repairs Allowance. There were revenue implications of the proposed demolition of a pair of semi-detached dwellings in the Monkton Road area which had been undermined by subsidence, as outlined in paragraphs 11 and 15.

Members queried about whether there were any other Orlit homes which had structural problems like the two homes being demolished. It was reported that the problems were with the precast concrete frame structure but officers were not anticipating finding other properties with the same problems.

Members raised concerns about the relocation of tenants into the Discus bungalows and requested that officers tried to minimise the number of elderly people moving more than once. Officers reported that figures could be provided on the number of tenants who want to move permanently and who were happy to move into temporary accommodation.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to:

i. Note the progress on schemes, approve variations in tables 1, 2 and 4 and note minor variations made under officers' delegated authority

ii. Agree the recommendation of demolition and payment of home loss as outlined in paragraphs 11 & 15.

iii. Approve the Revenue Contribution for funding of Adaptations to Discus Bungalow customers as noted in paragraph 18 and table 3.

iv. Consider the proposed capital programme schemes for 2007/08 to 2010/11 and recommend the proposals to the Budget Executive on 16th January 2007.

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To achieve a balanced capital budget.

57. Housing General Fund Service Plan – Second Monitor

Members received a report which provided the Executive Member with updates and progress on Housing General Fund Service Plan agreed from April 2006. A separate report detailed the Housing Revenue Account.

The original budget estimate for Housing General Fund approved by Members was £1,333k. After approval of savings and growth and other approvals including insurance and recharge adjustments, the approved Housing General Fund budget was now £1,212k. This review indicated that there was a forecast underspend of £67k.

Members commented that the figures on the percentage of minor adaptations installed within 7 days from assessment was exceptional.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to note the progress and achievements made in delivering the Housing General Fund Service Plan.

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To inform the Executive Member on progress on the service plan and progress against objectives.

58. Housing Revenue Account (HRA) Service Plan - Second Monitor

Members considered a report which provided the Executive Member with updates and progress on HRA Service Plan agreed from April 2006. A separate report detailed the Housing General Fund.

The original 2006/07 budget reported to members on 6th February 2006 had a working balance of £4,513k. After a number of budget adjustments, including the allocation of recharges and insurances, the balance on the HRA was now estimated to be £4,540k. The net variations of £295k together with the budgeted balance of £4,540k now gave a total estimated balance on the HRA of £4,835k. This was an increase of £22k since the first monitoring report that went to the executive member on 11th September 2006.

Members queried about the figures for non decent council housing stock in Annex 1 being different to those in paragraph 9 of the report. Officers reported that the figure of 12.78% in Annex 1 was the correct one and the figure of 14.79% in paragraph 9 should be 12.78%.

The Executive Member for Housing thanked staff in Housing Services for their work on the HRA and Housing General Fund.

Advice of the Advisory Panel

That the Executive Member for Housing be advised to note the progress and achievements made in delivering the HRA Service Plan.

Decision of the Executive Member for Housing

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To inform the Executive Member on progress on the service plan and progress against objectives.

59. Service Plans and Revenue Budget Estimates 2007/08

Members received a report which presented an update to the Service Plans for 2007/8 and the 2007/08 budget proposals for Adult Social Services.

A summary of the budget proposals was shown in Table 1 under paragraph 8. Annexes 2 and 3 contained budget service pressure proposals and savings options for the portfolio area.

The Labour Group reserved their position but commented that there were further cuts proposed in the budget, in conjunction with increased fees and charges.

Advice of the Advisory Panel

That the Executive Member for Adult Social Services be advised to

(i) Provide comments on the budget proposals for consultation for 2007/08

contained in this report, which will be considered by the Budget Executive on 16 January 2007;

(ii) Consider the budget proposals for consultation for Adult Social Services for 2007/08 contained in this report and listed below and provide comments to be submitted to the Budget Executive on 16 January 2007:

- 2007/08 Base budget as set out in Table 1;
- Service Pressure proposals as set out in Annex 2;
- Savings proposals as set out in Annex 3

Decision of the Executive Member for Adult Social Services

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To ensure a balanced 2007/08 budget is presented to the Executive.

60. Standard charges for the use of Residential Homes, Non-Residential Centres and Discretionary Social Care Charges

Members considered a report which sought approval for the level of charges to other local authorities for the use of services within the Social Services portfolio for residential care homes and non-residential centres, and of the maximum charge made to residents of the homes. The report also considered the level of discretionary social care charges.

The report advised that there are no alternative options regarding the standard weekly charges for residential care homes and non-residential centres as shown in Annex A. There was a legislative requirement that the charges were calculated following national guidelines provided to all local authorities. In arriving at the figures quoted the guidelines had been strictly followed.

There were alternative options to the discretionary charges in Annex B. These could include:-

- Option A would be to increase the discretionary charges to the amounts proposed within this report.
- Option B would be not to increase the discretionary charges but leave them at the 2006/07 rates or to increase them by less than the amounts proposed within this report.
- Option C would be to increase the discretionary charges by more than the amounts quoted within this report.

The Labour Group reserved their position but noted the significant reduction in the disability related benefits disregarded from 50% to 35%.

Advice of the Advisory Panel

That the Executive Member for Adult Social Services be advised to

(i) Consider the fees and charges proposals for consultation for Adult Social Services for 2007/08 contained in this report and listed below and provide comments to be submitted to the Budget Executive on 16 January 2007.

(ii) Approve the following charges to commence from 2nd April 2007

(a) the standard weekly charges for residential care homes and non-residential centres as shown in Annex A.

(b) the discretionary charges as shown in Annex B.

(c) the amount of disability related benefit disregarded reduces from 50% to 35% as per paragraphs 2.8 – 2.10.

Decision of the Executive Member for Adult Social Services

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To ensure a balanced 2007/08 budget is presented to the Executive.

61. Second Review of the 2006/07 Social Services Capital Programme and programme for 2007/08 to 2010/11

Members considered a report which presented the second quarter review of the 2006/07 Social Services Capital Programme and the resources available to support it.

The report advised that as there were no variations the Programme would remain at £671k of which £205k was grant funded income.

Advice of the Advisory Panel

That the Executive Member for Adult Social Services be advised to note the continuation of the existing capital programme schemes in future years as outlined in paragraph 8.

Decision of the Executive Member for Adult Social Services

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To inform the Executive Member and ensure a balanced capital programme in 2007/08.

62. Social Services 2006/7 Service Plan and Budget 2nd Monitor report

Members considered a report which provided an overview of progress on Service Plans agreed in January 2006. This report covered service plans for social services and corporate services. Elements of the Corporate Services monitoring were also relevant to the Housing service plans.

The original budget estimate approved by Members was £31.9m. After approval of savings and growth and other items, including insurance and recharge adjustments, the approved budget was £31.7m. This review indicates an overspend of £1,520k (4.8%) to the approved budget, compared to the first monitor which highlighted a potential overspend of £1,702k. If the actions being taken were achieved, the overspend could reduce to £648k, an increase of 2.2% to budget.

Members requested an update on the provision of home care services and the difficulties of providing this service. It was reported that as from 4 December the council had ceased to be the provider for long term care and that three providers for three different areas were now the providers. There had been initial problems with some companies that were not successful who did not do a handover of staff but these problems were now diminishing.

Members queried about the number of people expressing an interest in direct payment. Officers reported that they were anticipating around 113 people being interested. Concerns were raised by Members that some people were swapping to direct payment to maintain their current cover arrangements, but some companies were charging more than what the council was paying so people were having to top up their payments.

Advice of the Advisory Panel

That the Executive Member for Adult Social Services be advised to

(i) Note and comment on the progress made in delivering Adult Social Services and Corporate Services plans.

(ii) Note and comment on the projected overspend on adult social services and the measures taken and planned to reduce this.

Decision of the Executive Member for Adult Social Services

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To assure that the objectives for adult social services are being delivered in line with the agreed service plans. To ensure that robust plans are in place to bring expenditure on adult social services much closer to the approved budget.

63. Annual Review of Adult Social Services

Members considered a report which informed the Executive Member of the outcome of the annual performance rating by the Commission for Social Care Inspection (CSCI) of adult social services in York.

CSCI had written to the Director to confirm that the council continues to serve MOST people well and that the service had PROMISING PROSPECTS for improvement. The combination of these two assessments was a TWO STAR rating.

Members thanked staff for their hard work and commitment and welcomed the positive report. It was agreed that a note thanking staff would be sent out on behalf of the committee.

Advice of the Advisory Panel

That the Executive Member for Adult Social Services be advised to note and comment on the annual assessment of adult social care by CSCI.

Decision of the Executive Member for Adult Social Services

RESOLVED: That the advice of the Advisory Panel as set out above be accepted and endorsed.

REASON: To ensure that the improvements achieved in 2005/6 were recognised by the council and that members were aware of the areas highlighted for improvement in the future.

CLLR SUE SUNDERLAND
EXECUTIVE MEMBER FOR HOUSING

CLLR SUE GALLOWAY
EXECUTIVE MEMBER FOR ADULT SOCIAL SERVICES

CLLR JANET GREENWOOD
Chair of Advisory Panel
The meeting started at 5.00 pm and finished at 6.20 pm.

CITY OF YORK COUNCIL

HASS08

Meeting of the Executive Members for Housing and Adult Social Services and Advisory Panel

15th January 2007

Report of the Director of Housing and Adult Social Services

Rechargeable Repairs

Summary

1. The Executive Member for Housing is asked to approve a new approach to the recovery of rechargeable repairs.

Background

2. Where a tenant, member of the household or visitor has been responsible for damage to the home the department will recharge the tenant for the damage to the property.

3. The current approach has not been reviewed since 1992. The introduction of iworld and the partnering arrangements with neighbourhood services have partly prompted this review. In addition the poor performance in terms of recovery and various customer complaints have demonstrated that the service requires an overall.

4. There is currently over £100,000 worth of outstanding debt relating to rechargeable repairs owed to the authority. Ascertaining the recovery rate has been difficult but from the information on the financial ledger £19K has been recovered over a 2 year period.

5. During the review of the service it was found that many of the processes were antiquated, and were compounding staff ability to provide an effective and efficient service. Equally these processes were directly responsible for a poor recovery rate. The current approach taken to recharging is based on charging the customer the actual cost of the repair, unfortunately because this cannot be determined at the point when the repair is ordered, staff are unable to advise the customer immediately. The actual cost does not become available until the contractor has closed the job, this can, in some instances, be up to 3 months after the work has been completed, only then is an invoice sent out to the customer. It is recognised that recovery rates of any debt are directly linked to the speed at which the recovery process is started.

6. The administration involved in processing a rechargeable repair is largely paper based and requires duplication of effort. A lack of clarity about what can and can't be recharged has lead to unnecessary disputes with customers and ultimately cancellations of the recharges.

7. There are particular types of work that make up the majority of the recharges raised. The most commonly requested are:

- Gain Access/Lock changes
- Broken Windows
- Removal of rubbish

8. There are a number of rechargeable repairs that arise during the process of reletting a home or as a result of police investigations, the process of recovery in these circumstances are more complex and are still under review.

Consultation

9. The Federation of Resident Associations have been consulted on the proposals and support them.

Options

10. **Option 1**

Identify the most regularly ordered rechargeable repairs and put a fixed value on the charge based on historic cost data and officer experience. The charges would be increased annual in line with the building index. Raise the invoices using the iworld IT system. The recovery process will be done through the financial ledger by housing services. The list of repairs will be updated on a regular basis to ensure that it reflects the most common rechargeable repairs.

11. **Option 2**

Retain the existing system of recovery

Analysis

12. Option 1 - By putting fixed charges on the different types of work we will be able to inform customers of the total charge to them at the point when the work is ordered. Payment will be required at the time the request is made, reducing the need to generate the administration required in the recovery process. Where work is deemed necessary to ensure that the property remains wind and weather tight, or is of a health and safety nature, if payment is not made in advance, works will be ordered and recharged to the tenants. In circumstances of hardship at the very least staff will be able to agree a payment plan and send the invoice out within days of the work being ordered. A list of the proposed charges are contain in appendix 1.

13. Option 2 – Current levels of performance will not significantly increase, tenants will continue to be confused by the process and unhappy at not knowing what the likely cost to them will be.

Corporate Priorities

14. Specific links can be made to the following:

- Improving our organisational effectiveness
- Improve efficiency and reduce waste to free-up more resources.

Implications

15 Implications arising from this report are:

- **Financial** - Approximately £50k of rechargeable repairs are carried out each year. Depending on the types of repair, option 1 could result in either an under or over recovery of costs. Should there be a surplus, this will be retained in the HRA and reinvested in the housing service. Any deficit would need to be funded from the general repairs budget. As this budget is currently overspending this represents a financial risk. However, analysis of previous years activity suggests that no significant balance is anticipated.
- **Human Resources (HR)** - none
- **Equalities** - none
- **Legal** - none
- **Crime and Disorder** - none
- **Information Technology (IT)** - There are alterations required to the iworld system and there needs to be an interface between this system and the financial management system to allow this process to work.
- **Property** - none
- **Other** - none

Risk Management

16. The risks in not implementing the proposed changes outlined in option 1 is that the council will continue to confuse customers and the recovery rate on charges raised will continue to be poor. The authority also risks criticism by the housing inspectorate at any future inspection of the service.

Recommendations

17. That the Advisory Panel advise the Executive Member to approve Option 1 to identify the most regularly ordered rechargeable repairs and put a fixed value on the charge based on historic cost data and officer experience.

    Reason - It will lead to an improved service to, and greater clarity for, customers, it will also result in greater efficiency for the council.

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Report Approved √ **Date** 22nd Dec 06

Report Approved √ **Date** 22nd Dec 06

Specialist Implications Officer(s) List information for all

Implication Financial	Implication ie Legal
Name Jayne Pearce	Name
Title Accountant	Title
Tel No. (01904) 554175	Tel No.

Wards Affected: *List wards or tick box to indicate all* **All** √

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A - List of common rechargeable repairs and the proposed charges

Annex 1

Proposed rechargeable rates for the most common repairs raised

Gain Access to Property - £25.00

Change lock (priced per lock) - 30.00

Glazing (priced per square of glass) - £60.00

Call out to gas meters, quantum meters, no gas (tenants responsibility) - £40.00

Leaks (gas and water) due to nailed/drilled pipes - £70.00

Washing machine leaks, tap connectors, hoses (tenants responsibility) - £30.00

Board ups (no glazing) - £25.00

Rubbish removal - £70.00

Abortive visits - £25.00

Replace damaged internal doors - £75.00

Call out to customers DIY work - £30.00

Replace light fitting/switch (priced per fitting) - £30.00

All prices are exclusive of VAT

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CITY OF YORK COUNCIL

HASS14

Meeting of the Executive Members for Housing and Adult Social Services and Advisory Panel — **15th January 2007**

Executive Member For Leisure & Culture and Advisory Panel — **16th January 2007**

Report of the Assistant Director (Lifelong Learning and Culture)

Proposal to Designate Acomb Wood & Acomb Meadow as a Statutory Local Nature Reserve

Summary

1. The paper proposes that Acomb Wood & Acomb Meadow be declared a Local Nature Reserve as part of the development of a city wide network of Local Nature Reserves (LNR's). Acomb Wood & Meadow are situated in the Dringhouses & Woodthorpe Ward of the City, bordering Westfield Ward. Because parts of the site are in differing Executive portfolios the report is presented to both Executive members and advisory panels for approval.

Background

2. The City of York Council is the freeholder of both Acomb Wood and Acomb Meadow. Together they cover 4Ha (10 Acres) of land (3.1Ha woodland, 0.9 Ha Meadow). Acomb Wood is in the Leisure & Culture portfolio and Acomb Wood Meadow in the Housing Services portfolio.

3. LNR's are both for people and nature - they are places with wildlife or geological features that are of special interest locally. Through good management it is possible to give people special opportunities to study and learn about them or simply enjoy and have contact with nature. There are over 1000 LNRs in England today ranging from windswept coastal headlands, ancient woodlands and flower meadows to former inner city railways, long abandoned landfill sites and industrial areas. In total they cover over 40,000 hectares, forming an impressive natural resource which makes an important contribution to England's biodiversity. However LNRs are comparatively scarce in North Yorkshire – with only 15 recognised sites, 3 of which are within York. Clifton Backies LNR was the first within York (designated 2002), Hob Moor LNR the second (designated 2003) and St Nicholas Fields LNR the third (designated 2004).

4. LNR designation serves to;

   - increase people's awareness and enjoyment of their natural environment.
   - provide an ideal environment for everyone to learn about and study nature.
   - build relationships between local Authorities, national and local nature conservation organisations, and local people.
   - protect wildlife habitats and natural features.
   - offer a positive use for land which local authorities would prefer was left undeveloped
   - make it possible to apply by-laws which can help in managing and protecting the site.

5. A Memo of Understanding is in place between the Friends of Acomb Wood (FoAW), the Dringhouses & Woodthorpe and Westfield Ward Committees, and the City of York Council Parks & Open Spaces Section. This agreement came into being as a part of the acquisition of the woodland in 2002.

6. Current Conservation designations on the site are Statutory Local Nature Reserve (proposed) (full site), Site of Importance for Nature Conservation (City of York Council Local Plan) (Meadow only), and Tree Preservation Order (Woodland only & those trees behind Linnet Way.)

7. Acomb Wood is an old plantation dating back over 200 years. It is a mature, even aged woodland dominated mainly by Oak with an under storey of hazel, bramble, and hazel. There are also abundant hornbeams and birch with occasional rowan, whitebeam, scots pine and black poplars. There are also remnant old hedgerows showing evidence of once being laid using traditional techniques. This largely native woodland is home to numerous species of fungus, invertebrates, and mammals and supports bird species such as tree creeper, wood pecker, tawny owl and sparrow hawk. The woodland is a welcome refuge amongst a heavily urbanised area.

8. The adjacent meadow complements the woodland and also accommodates a woodland edge habitat. These edge habitats and substantial hedgerows are an extremely important element of the woodland ecosystem. The meadow itself shows a ridge and furrow landscape demonstrating that it has been managed as grassland for the past 300 years. This small area of unimproved grassland is the last of it's kind in this area of the City mainly due to development. This meadow is species rich and includes several species of fine grasses long with wildflowers such as birds foot trefoil, meadowsweet, knapweed, meadow Vetchling and tufted vetch. A herb rich meadow such as this supports a large diversity of invertebrates, which in turn support bird populations and small mammal such as wood mouse, filed vole, bank vole, shrew and weasel.

9. Community involvement in the Meadow and Wood is the primary responsibility of the Parks & Open Spaces Community Leisure Officer. At least 10 public activities are held annually, such as guided walks and practical tasks. Community and environmental groups such as the Friends of Acomb Wood, Yorkshire Wildlife Trust Running Wild! group, British Trust for Conservation Volunteers, University Conservation Volunteers, York Cares volunteers and Environmental Task Force and others have all helped out on site. Members of the wider public are also

encouraged to participate. If the LNR designation is fulfilled, this community involvement will be carried out by the LNR Officer within the Parks and Open Spaces section.

Consultation

10. As part of the process of developing a Management Plan for Acomb Wood & Meadow the Friends of Acomb Wood have been consulted as to the designation of the site as an LNR and it's future management. Management operations are overseen and administered by the Parks & Open Spaces section and are implemented primarily by Commercial Service staff with smaller scale works undertaken by the Friends and other volunteer groups.

11. The Dringhouses & Woodthorpe, and Westfield Ward Committees have been consulted and have had commented on the designation and future management of the wood. Other groups who have had the opportunity to have an input to the management plan are Yorkshire Wildlife Trust, York Natural Environment Trust, Natural England, Tree Wardens, members of the York Natural Environment Panel, members of the public and numerous council officers from the environment & conservation, parks & open spaces, and public rights of way sections.

12. In line with the protocol for designation of any site as an LNR, as stipulated in National Parks & Countryside Act 1949, Natural England (the Statutory Nature Conservation Body for England) have been consulted. Natural England support the designation of Acomb Wood & Meadow as an LNR.

Options

13. **Option 1:** Declare Acomb Wood & Acomb Meadow as a Local Nature Reserve.

14. **Option 2:** Do not declare Acomb Wood & Acomb Meadow as a Local Nature Reserve.

Analysis

15. The advantages of designating the site as a Local Nature Reserve are;

    i) LNR designation is statutory, so that in planning terms protection of the site would be enhanced.

    ii) Additional advisory assistance would be available from Natural England. Financial assistance has been available in the past, and will continue to be available in the future as new grant schemes are developed and come under the administration of Natural England.

    iii) The designation may help to secure funding from other sources, for example landfill tax credits, and various arms of the Big Lottery Fund.

16. If Acomb Wood and Meadow was not declared as a Local Nature Reserve, certain grant scheme options would be closed to application and expert advice and support from Natural England would not be accessible. In addition the extra protection from development and the benefits of a public designation would not be felt by the local community.

Corporate Objectives

17. The designation as an LNR helps to meet Corporate Aim 1, as stipulated in the Council Plan 2006/07, to take pride in the City by improving quality and sustainability, creating a clean and safe environment.

18. The knock-on effects and benefits of LNR designation will also help to meet Corporate Aims 2, 5 & 7 by improving opportunities for learning, improving health & well being, and developing opportunities for events & activities.

19. The designation of, and increase in the number of Local Nature Reserves within York are targets within the Parks & Open Spaces Service Plan for 2006/07. The designation of Acomb Wood & Meadow is stipulated within this plan – to increase the number for LNR sites from 3 to 4, along with aspirations to increase the overall area of land under LNR designation, from 52.5 hectares to 62.5 hectares.

Implications

20.

- **Financial** The only cost to the Authority is the cost of advertising the designation status, which can be met within the existing Parks & Open Spaces budget. The designation in the long term is likely to bring significant investment in to the city as it opens up more funding opportunities for the Friends along with other community groups.

- **Human Resources (HR)** There are no HR implications.

- **Equalities** There are no Equalities implications.

- **Legal** There are no legal implications. The National Parks and Access to the Countryside Act 1949 gives powers to Local Authorities to designate LNRs. The local authority must have legal interest in the land, for example by owning it, leasing it or having an agreement with the owner. The land must also be within the area of the local authority.

- **Crime and Disorder** There are no Crime & Disorder implications.

- **Information Technology (IT)** There are no IT implications.

- **Property** There are no Property implications.

- **Other** There are no other implications.

Risk Management

20. There are no known risks associated with the designation of Acomb Wood & Meadow as a Local Nature Reserve.

The Next Steps

21. Should the decision be made to designate Acomb Wood and Meadow as an LNR the Council would be required to notify the Public. This would take the form of an advert in the Press and copies of the declaration would be made available for public inspection at 18 Back Swinegate. Notices would also be placed on site, and publicity through the Press and Ward Committee Newsletters sought. Natural England would be informed to update the national database of LNRs and Ordnance Survey informed for updating the status on their maps.

Recommendations

22. That the Advisory Panel advise the Executive Member that Acomb Wood & Acomb Meadow be designated as a Local Nature Reserve, per Option 1 above.

    Reason: The designation as an LNR will bring positive benefits to the local community and to the site itself. It will help preserve & enhance the site for future years, send a positive message to the local community, and ensure good management practices are followed in consultation with Natural England.

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Report Approved √ **Date** 29/12/06

Charlie Croft
Assistant Director, Lifelong Learning and Culture

Report Approved √ **Date** Insert Date

Specialist Implications Officer(s)
Nil

Wards Affected: Dringhouses & Woodthorpe, Westfield **All** tick

For further information please contact the author of the report

Background Papers: None

Annexes:

Annex 1 : Area & Location of Proposed LNR Designation

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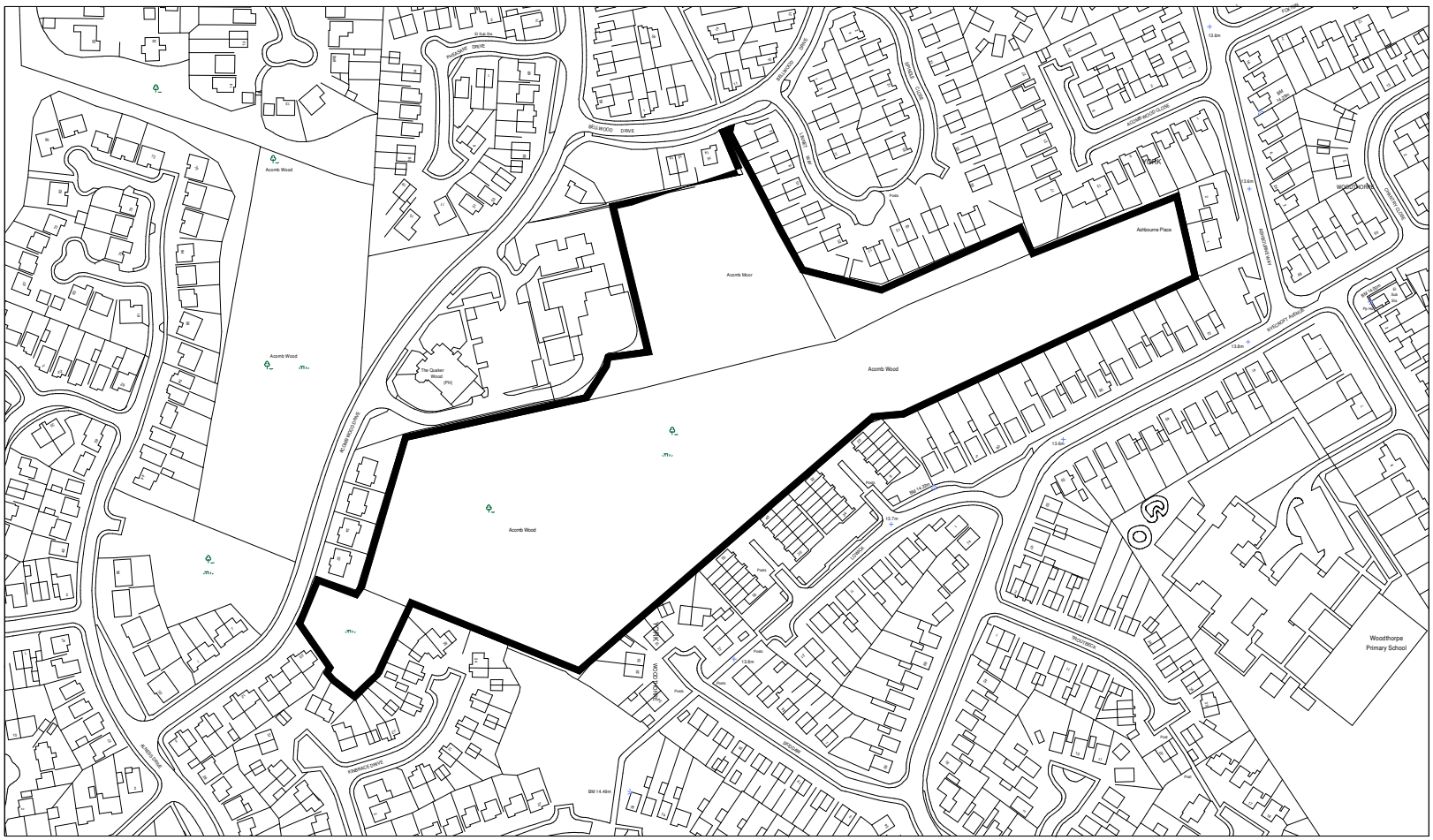
Annex 1: Acomb Wood & Acomb Meadow – Area & Location of Proposed LNR Designation



Acomb Meadow & Acomb Wood

SCALE: 1:2500 DRAWN BY: Barrie Jones DATE 3/12/2002

Originating Group: Organisation

Drawing No.

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CS2310

Meeting of the Executive Members for Housing and Adult Services and Advisory Panel

15th January 2007

Report of the Director of Housing and Adult Social Services

RESULTS OF THE 2006 ANNUAL HOUSING SERVICE MONITOR

Summary

1. This report provides the Executive Member with the headline results of the Annual housing Services Monitor: a postal survey undertaken during September and October 2006. It will be supplemented by a presentation to the Executive Member and Advisory Panel at the meeting.

2. The departments response to these findings will be worked up as part of the service planning process, and included in the Service plan reports being brought to the Executive member in March 2007 For ease of reference percentages have been "rounded", with a full breakdown of response rates for key questions shown in ***Figures 1 to 33*** set out in ***Annex A***.

Background

3. The Annual Housing Services Monitor is a tenant satisfaction survey which has been carried out in York every year since 1990.

4. During September 2006 a postal survey was mailed to 1800 council tenants selected at random. A total of 878 tenants returned the questionnaire which represents a good response rate of 49% of the sample. The survey was promoted using the *Streets Ahead* publication, posters in housing offices and press releases. A prize draw with a top prize of £200 was also offered in to increase the response rate.

5. The Marketing and Communications Group developed the questionnaire in conjunction with the Housing Services department. The fieldwork was conducted by BMG research.

6. The 2006 research was a statutory BVPI (Best Value Performance Indicator) survey. Every three years the council is required to report four BVPI indicators using responses to standard questions based the 'STATUS' survey. The Housing Service is able to add additional questions, but all the questions specified by the DCLG (Department for Communities and Local Government) must be included. Previously in York, the survey has been

conducted using face-to-face interviews, however this year the Audit Commission specified a postal methodology. This change in data collection methods should be borne in mind when comparing the 2006 results with previous findings. The results for the BVPI stats are shown in **Charts 1 and 4** contained below.

Data issues

7. The Annual Housing Services Monitor results are accurate to within +/- 3.3% with 95% confidence. Where percentages do not sum to 100%, this is either due too multiple responses or decimal rounding. The figures for each question have been calculated after the respondents ho did not answer the questions have been removed from the bases. Data is available broken down by a number of categories including, age, residents association area and estate. Ward level analysis will also be available shortly to us from BMG who carried out the survey. The Annual Housing Service Monitor contains questions relating to tenants' profile; satisfaction with housing and neighbourhoods; recent contact with the Council; satisfaction with the repairs services and satisfaction with methods of communication and involvement.

8. The response numbers from the BME (Black and Minority Ethnic) community were too low to be statistically valid.

Consultation

9. The survey questionnaire was designed by Marketing and Communications in conjunction with Housing managers, and included all the statutory questions required by the STATUS survey (see paragraph 6 above). The results of the survey will be shared with the York Federation of Residents and Community Associations at their January 2007 meeting, and in the March 2007 edition of *Streets Ahead* Magazine for tenants. Detailed feedback for staff on both general trend and their specific service areas will also be provided.

Options

10. This report is information only.

Analysis

Tenant Profile

11. The majority of the sample were longstanding tenants of City of York Council 60% have been a council tenant for over 10 years and almost half have lived in the same home for more than 10 years. ***(Figure 3)***

12. In terms of ethnic group, the returns were dominated by White British (98%). This compares with the 2001 census figure of 2.1% for all households in York. Only 6 responses from Black and Minority Ethnic tenants were

received, although the survey was offered in other languages and formats. (See ***Figure 6***)

13. One third of households participating in the survey were made up of one adult aged 60 years or older, a further 11% were made up of 2 adults aged 60 years or older. Single parent families with at least one child under 16 accounted for 15% and two parent families 8% of respondents. ***(Figure 1)***

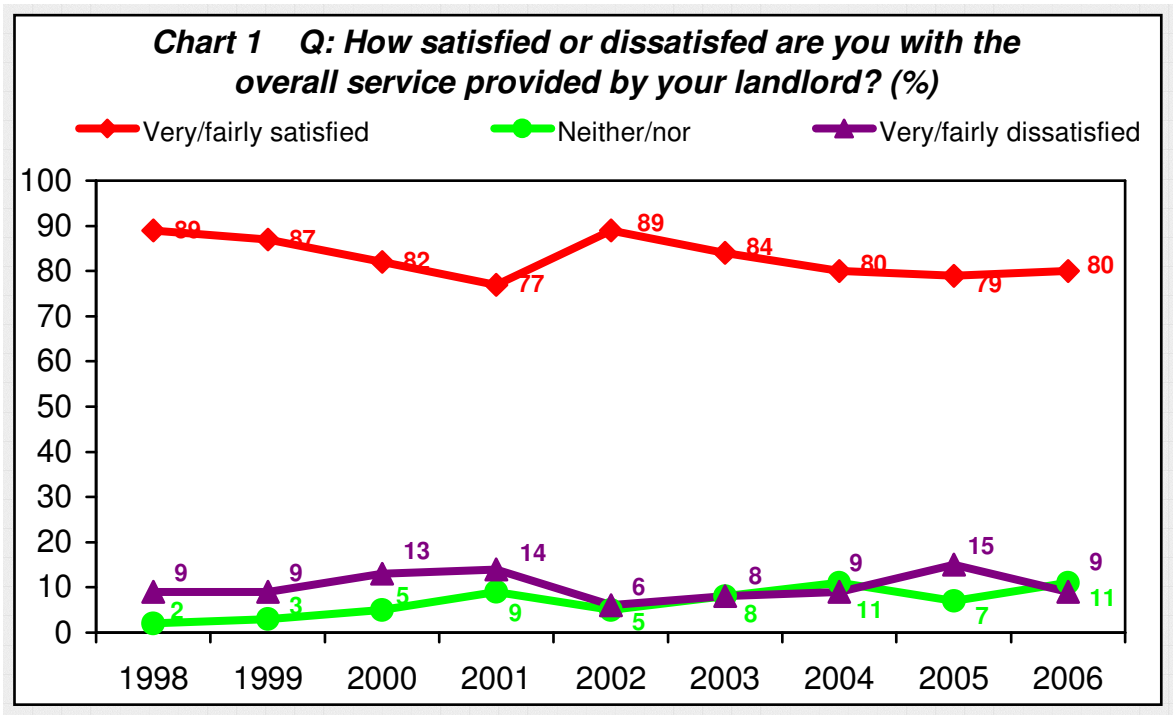
14. The largest number of respondents (40%) had been council tenants for over 21 years, and 29% had lived in their current home for over 21 years. More detail on the breakdown of responses by length of tenancy and time in home is shown in ***Figures 2 and 3.***

15. In terms of economic activity, 39% of the respondents were retired; over a quarter (29%) employed or self employed; 14% permanently sick or disabled, and 10% looking after home or family. ***Figures 4 & 5*** give more information on sources of income.

16. Households with an annual income of less than £10,400 account for 63% of the sample, and 59% receive all their income from benefits and/or pensions.

17. Forty six per cent of respondents to the survey responded 'Yes' to the question *'Do you have any longstanding illness, disability or infirmity?'* ***Figure 7***

Overall satisfaction with the Housing Service



18. Satisfaction with the overall service remains high, and 80% of tenants stating that they are 'very' or 'fairly' satisfied, is an improvement on the 2005 response. The percentage 'very dissatisfied ' has halved from 6 to 3%, and those feeling dissatisfied have reducing from 9 to 6 %: overall 9% of tenants are dissatisfied; and 11% 'neither satisfied or dissatisfied' (***Figure 8)***. Amongst people citing a disability or long term illness, satisfaction is broadly similar to the overall figure, at 79%, and there are no significant differences in responses by this group to other survey questions. The longer term trend is shown in **Chart 1** above.

19. 76 per cent of tenants agree (strongly or slightly) that City of York Council is a good landlord (***Figure 9).*** This outturn is six percentage points below the 2005 result of 82%. Further detailed analysis of the results will be undertaken to discover the reasons as to why the proportion of tenants agreeing that the Council is a good landlord is continuing to decrease.

Satisfaction with home and surrounding area

20. The condition of the home ***(Figure 12)*** is described as 'good' or 'very good' by 80% of tenants a 1% increase on last year. The numbers stating fair or poor has reduced from 12 to 8%. Again satisfaction is much higher among the over 55 age group: 89% say their home is in good or very good condition compared to 65% of 16-34 year olds, and 70% of 35-54 year olds. Further research needs to be undertaken to discover the reasons for this

21. Eighty three per cent of tenants are satisfied (including 49% very satisfied) with their accommodation ***(Figure 10***), down from 87% in 2005. There is a variation among age groups, and 92% of over 55 year olds are very or fairly satisfied. Only 77% ***(Figure 11)*** state that the number of rooms in their home is 'about right'. Eighteen per cent have too few rooms, and 5% (up from 2%) have too many. The council has not changed its policy on the size of properties in relation to the size of households, it is likely therefore that this trend is more a reflection on aspirational issues such a desire for additional rooms for home study or computer use.

22. Thirty seven of respondents lived in part of a communal development (generally flats or bedsits). And 71% of these residents are satisfied with the way that the council looks after these areas **(*Figure 13.*)** This has fallen from 74% in 2005. However, when asked to rate satisfaction with particular aspects of the communal responses showed a marked improvement in relation to repairs to communal areas with 80% satisfied, and satisfaction with decoration, bin chutes and door entry phones also improved. Satisfaction with cleanliness remained the same as 2005, at 67%.

23. There was a decline in satisfaction with the maintenance of outdoor communal areas ***(Figure 16)*** – this fell to 67% this year from 77% in 2005. However, when asked about particular aspects of outside space:

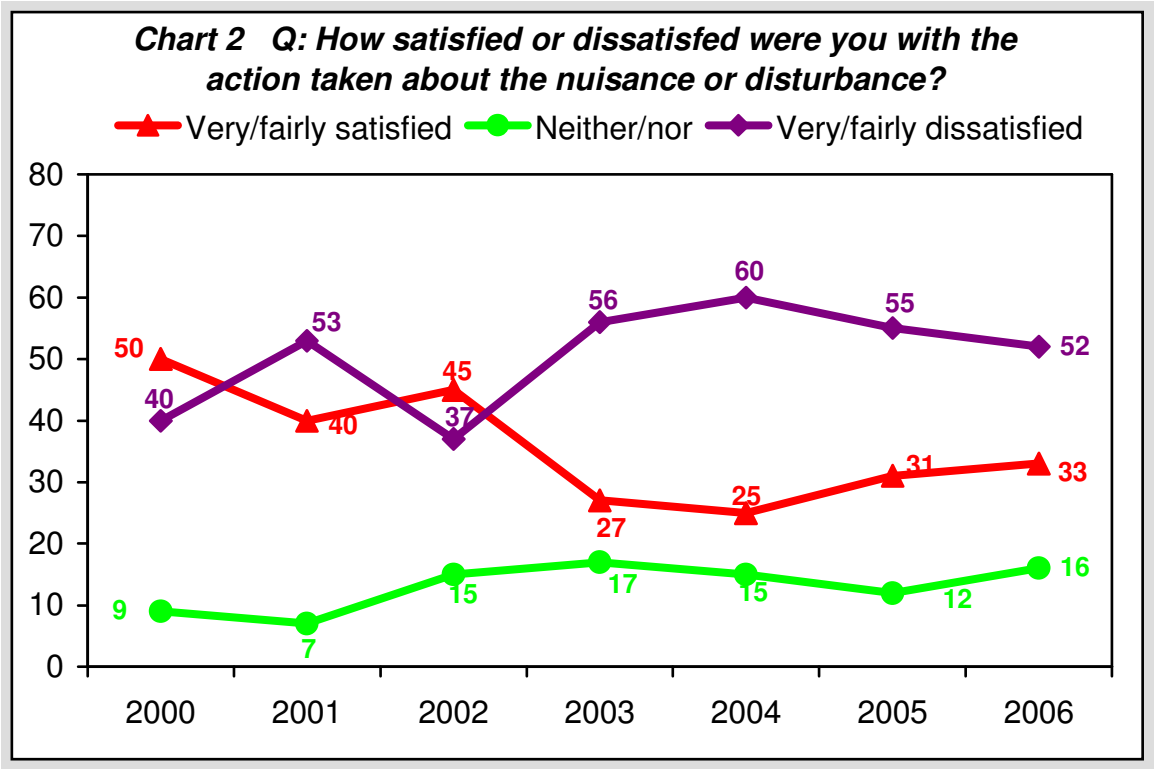
    - satisfaction with grass cutting improved from 67 to 71%,

    - the maintenance of shrubs and trees rose from 59 to 66%,

- the removal of graffiti by 18 percentage points from 43% in 2005 to 61% this year.

24. When asked about the wider neighbourhood over three quarters (76%) are 'satisfied with their neighbourhood as a place to live'. ***(Figure 14)*** This is an improvement on 74% in 2005 and reverses a downward trend. Those least satisfied were younger people, those with children and those in employment. Respondents in the Tang Hall (centre and north) were the least satisfied (59%) followed by Bell Farm with 68% satisfaction. Residents in Cornlands and Chapelfields displayed the greatest satisfaction, with both estates rating 83%.

Nuisance

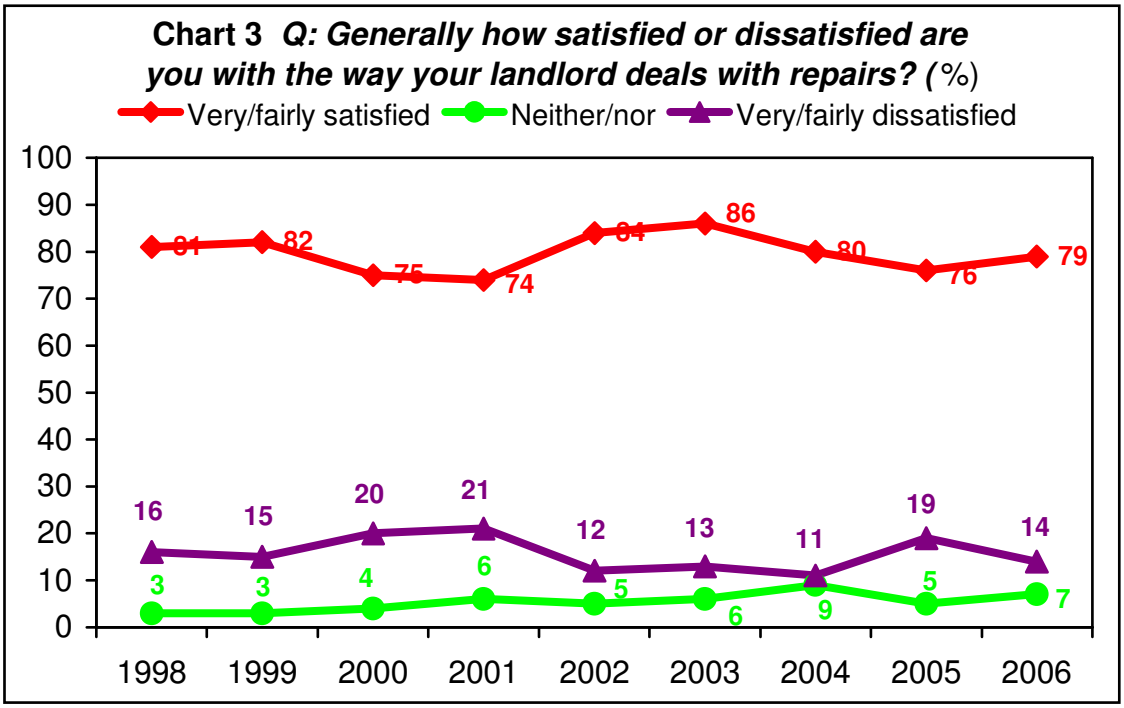


25. Respondents were asked about their personal experience of nuisance ***(Figure 17)***. Whilst 51% consider noise from other people to be a problem in the area, and 36% cited neighbour problems as an issue, only 16% had reported nuisance or disturbance from neighbours in the last 12 months. Reporting of nuisance issues was highest in Villages, and in Carr and Foxwood areas (with around a quarter of tenants reporting nuisance, and lowest in Chapelfields and Lowfields (6%)

26. One third of the tenants who reported a problem were satisfied with the action taken ***(Chart 2 above & figure 18)*** This is the highest rating since 2002, although the numbers are decreasing, over half remain dissatisfied with the action taken as the result of their complaint. Views on more the

more general incidence of Anti-social behaviour in their area is contained in paragraph 35.

The Repairs Service



27. The proportion of tenants satisfied with the repairs and maintenance service has increased to 79% from 77% in 2005 ***(Figure 25)*** Again the youngest respondents had the lowest levels of satisfaction: 90% of over 55s were satisfied with the repairs service compared to only 59% of 16-34 year olds.

28. Over two-thirds (67%) of tenants have requested repair work in the last 12 months. ***(Figure 26)*** Those tenants who had repairs completed in the past year were asked to rate the repairs service for various attributes ***(Figure 27)***. In all areas the majority of tenants were satisfied, in particular 9 out of 10 reported the attitude of workers had been good. They were most critical in terms of the time taken for work to start, with only 78% satisfied down from 84% in 2005.

29. These issues have been discussed by the Repairs Partnership Board, which monitors the partnership arrangement between housing and Neighbourhood Services to deliver responsive repairs, and the HRA (Housing Revenue Account) service plan submitted in March 2007 will include actions to address repair issues highlighted by the survey).

Communications & Customer Service

30. Three quarters of respondents are very or fairly satisfied with the way the housing department keeps them informed about the things which might affect them as a tenant. The number very satisfied has increased from 29% in 2003 to 35% in 2006 ***(Figure 28)*** Satisfaction is higher amongst the unemployed over 55s and those without children. Longer standing tenants of 11 years plus were also more like to be satisfied (83%)

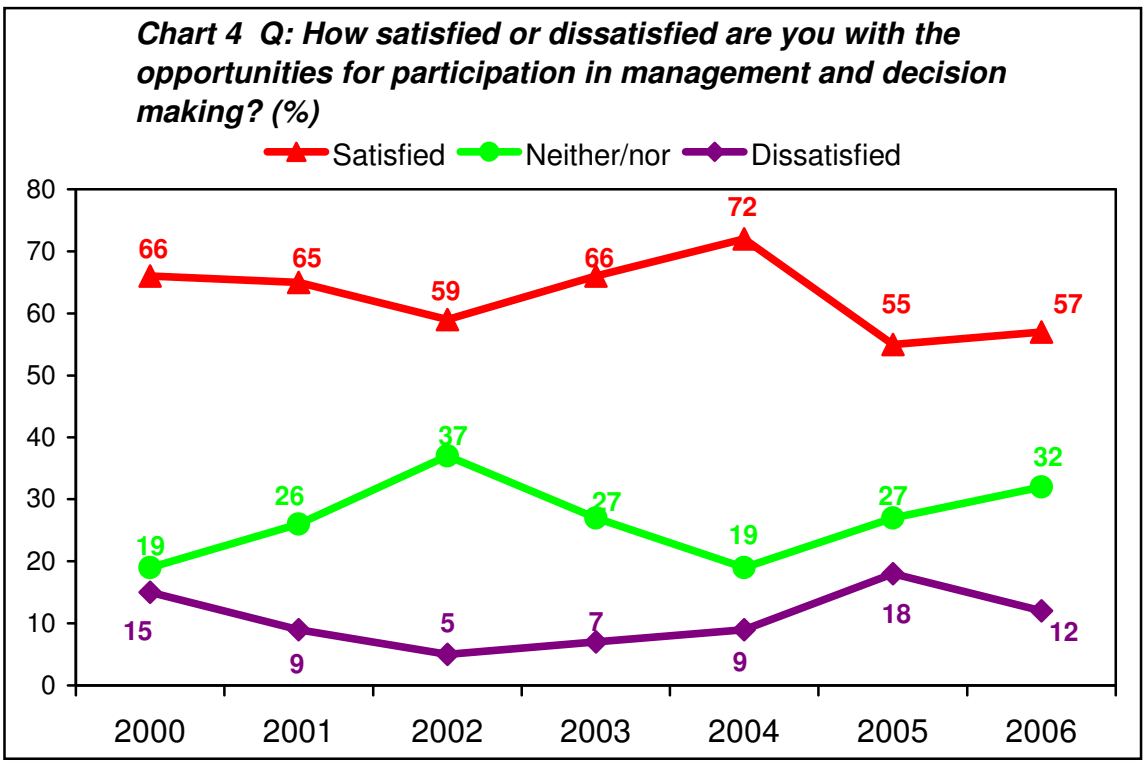
31. Respondents were asked about satisfaction with the council's magazine for tenants *Streets Ahead.* 91% of respondents recalled receiving a copy up from 88% last year. 96% of those read at least some of the magazine, with 62% reading all or nearly all of it ***(Figure 31)***

32. 60% of the sample had contacted the housing department in the last 12 months, with younger respondents and those who had been in their home for less than two years the most likely to have done so. 60% used the phone to make contact, 27% visited in person, and 1% each wrote a letter or emailed, Responses suggest that getting hold of the right person in the housing department is becoming increasingly difficult (down from 74 to 61%). This may reflect the initial impact of changes to staffing arrangements following the restructure in late 2005, and changes specialisation of estate manager roles, to separate responsibility for income and tenancy management However the perceived helpfulness of staff continues to improve increasing to 81% from 74% in 2005. In 77% of cases staff were cited as being able to deal with the enquiry. ***(See Figures 20-24)***

Tenant Involvement

33. Another question testing satisfaction with tenant involvement is satisfaction with opportunities for participation in management and decision making, one of the BVPI indicators. There is a small improvement in satisfaction in this area rising from 55 to 57%. (See ***Chart 4*** below)

Chart 4 Q: How satisfied or dissatisfied are you with the opportunities for participation in management and decision making? (%)



34. The survey asked tenants about satisfaction with the extent to which the housing department finds out their views ***(Figure 28)*** This has remained fairly stable, reducing only 1 percentage point from 65 to 64% satisfaction. However this is not satisfactory and further work needs to be done to establish the reasons for this, including the differences between age groups.

Wider Crime and Disorder Issues

35. Specific questions were asked about how much of a problem tenants perceived crime and anti-social behaviour to be problems in their area. The highest proportion of residents 66% overall, perceived vandalism to be a slight or serous problem in their area. It is also the issue most likely to be described as a 'serious' problem (by 19%) ***(Figure 15)*** Similar increases were reported in the perception of the following as a problem:

    - Litter 63%
    - Dogs 54%
    - Noise from people 51%
    - Drug dealing 46%
    - Graffiti, 45% (although only 6% view as a serious problem)
    - Racial harassment is perceived as a serious problem by 2% of residents, a further 6% referring to it as a slight problem.

36. The increasing concern about aspects of anti social behaviour highlighted by the survey warrants further research.

Responding and Improving Services

37. Overall, the results from the survey have been largely positive with eight out of ten respondents being satisfied with the overall service provided by the Council's Housing department

38. There has been a slight decline in satisfaction with accommodation and value for money, however the results are still strong with 83% and 74% expressing satisfaction

39. When presented with a list of services and asked to rate the three most important in terms of their importance, tenants ranked them as follows: ***(Figure 32)***

    - Repairs and Maintenance – 80% cited as one of the three most important
    - Overall Quality of Home- 58% (down from 73% in 2005)
    - Value for money of rent – 50%

- Keeping tenants informed 45%
- Taking tenants views into account 35%
- Involving tenants in management of homes (up to 11% from 7%)

40. The Questionnaire then asked tenants which of the above services most needed improving. Here the results were more evenly spread, 49% cited repairs, 51% overall quality, 35% value for money, 49 % keeping tenants informed, 54% taking tenants views into account, and 43% involving tenants in the management of homes. All these were within 7% points of the pervious years figures, except involving tenants in management of homes, which increased from 30 to 43%. ***(Figure 33)***

41. The Housing Revenue Account (HRA) Service Plan for 2007/8 submitted to EMAP in December 2006 highlighted the Government's Respect Agenda for Anti Social behaviour as a key service driver and priority, and joint working between the housing service and key stakeholders towards meeting the standard, could have a significant impact on anti social behaviour.

Corporate Priorities

42. The collection of the data used in the Annual Housing Monitor reflects one of the overall corporate priorities which is to: '*Improve our focus on the needs of customers and residents in designing and providing services'* Whilst the survey does note directly affect the actual condition of properties, it contributes to the priority action '*Improve the actual and perceived condition and appearance of city's streets, housing estates and publicly accessible spaces'* by measuring customer perceptions of housing and estates, to provide information to the housing service to inform service improvements

43. The findings from the survey can also be used to inform the priority statement '*Improve the quality and availability of decent affordable homes in the city'* by clarifying quality issues of concern to tenants.

Implications

44. Implications arising from this report are:

- **Financial -**There are no financial implications arising directly from this report.
- **Human Resources (HR) -** There are no HR implications
- **Equalities** - There are no direct equalities implications arising directly from this report. The results have been analysed to show differences in responses by age group, and can be interrogated to reveal responses given by people with disability or limiting long term illness, in terms of analysis by ethnic origin, as the base of ethnic minority respondents is low, further work needs to be done to establish the views and aspirations of this group.

- **Legal** - There are no legal implications
- **Crime and Disorder -** Some of the responses indicate tenants' views on Crime and Disorder issues, and the Housing Service will work in partnership to address these concerns, and to respond to the Governments 'Respect' Agenda to tackle anti-social behaviour.
- **Information Technology (IT) -** There are no IT implications
- **Property** - There are no Property Implications
- **Other -** No other known implications

Risk Management

45. There are no risks associated directly with this report.

Recommendations

46. That the Advisory Panel advise the Executive Member notes the summary results of the 2006 Annual Housing Service Monitor.

Reason*:* This report is for information only.

Contact Details

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Report Approved	√	**Date**	22nd Dec 06
Report Approved	√	**Date**	*22nd Dec 06*

Specialist Implications Officer(s) *None .*

Wards Affected: *List wards or tick box to indicate all* **All** √

For further information please contact the author of the report

Background Papers:

None

Annexes

Annex A: Tables showing detailed results from Annual Housing Monitor 2006

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Annex A: Annual Housing Monitor Initial Results 2006

Tenant Profile

Figure 1: Which of these best describes the composition of your household?

Response	Number of responses	Percentage 2006	Percentage 2005
One adult under 60	159	19.8%	15.2%
One adult aged 60 or over	265	32.8%	29.2%
Two adults both under 60	60	7.5%	10.2%
Two adults, at least one 60 or over	92	11.4%	11.8%
Three or more adults, 16 or over	27	3.4%	4.9%
One-parent family with child/ren, at least one under 16	119	14.8%	12.8%
Two-parent family with child/ren, at least one under 16	63	7.8%	14.5%
Other	20	2.5%	1.4%
Total number of responses	**805**		

Figure 2: How long have you been a council tenant in York?

[Response options amended in 2006.]

Response	Number of responses	Percentage 2006
Under 1 year	41	5%
1 – 2 years	76	9%
3 – 5 years	97	11%
6 – 10 years	114	13%
11 – 20 years	166	19%
21 + years	352	40%
Don't know	19	2%
Not stated	13	1%
Total number of responses	**878**	

Figure 3: How long have you lived in your present home?

[Response options amended in 2006.]

Response	Number of responses	Percentage 2006
Under 1 year	63	7%
1 – 2 years	104	12%
3 – 5 years	141	16%
6 – 10 years	130	15%
11 – 20 years	156	18%
21 + years	258	29%
Don't know	6	1%
Not stated	20	2%
Total number of responses	**878**	

Figure 4: What types of income do you and your partner receive?

Response	Number of responses	Percentage 2006	Percentage 2005
Earnings from employment or self-employment	233	26.5%	32.1%
Pension from a former employer	162	18.5%	21.2%
State pension	340	38.7%	41.0%
Pension tax credit	120	13.7%	9.2%
Child benefit	171	19.5%	25.4%
Job Seeker's Allowance	33	3.8%	4.4%
Income Support	214	24.4%	28.8%
Disabled Living Allowance / Attendance Allowance	165	18.8%	19.9%
Other state benefits	68	7.7%	19.2%
Interest from savings, etc	33	3.8%	1.1%
Other kinds of allowance form outside household	5	0.6%	1.1%
Working tax credit	73	8.3%	7.6%
Child tax credit	126	14.3%	13.4%
Other sources	12	1.4%	3.3%
Total number of respondents	**878**		

Figure 5: Which group represents your (and partner's) total net income from all these sources after deductions for income tax and national insurance? (Weekly)

Response	Number of responses	Percentage 2006	Percentage 2005
Under £60	84	11.7%	1.6%
£60 - £99	157	21.8%	11.4%
£100 - £159	204	28.4%	43.8%
£160 - £199	103	14.3%	16.9%
£200 - £299	115	16.0%	15.3%
£300 - £399	38	5.3%	6.0%
£400 or more	18	2.5%	5.0%
Total number of responses	**719**		

Figure 6: How would you describe yourself?

Response	Number of responses	Percentage 2006	Percentage 2005
White – British	847	98.0%	98.2%
White – Irish	4	0.5%	0.0%
White – Other	7	0.8%	0.6%
Mixed – White and Black Caribbean	1	0.1%	0.2%
Mixed – White and Black African	1	0.1%	0.0%
Mixed – White and Asian			0.0%
Mixed – Other			0.0%
Asian or Asian British – Indian	2	0.2%	0.3%
Asian or Asian British – Pakistani			0.0%
Asian or Asian British – Bangladeshi			0.2%
Any other Asian background	1	0.1%	0.0%
Black or Black British – Caribbean			0.0%
Black or Black British – African			0.2%
Any other Black background			0.0%
Chinese			0.5%
Other ethnic group	2	0.2%	0.0%
Total number of responses	**864**		

Figure 7: Do you have any longstanding illness, disability or infirmity?

Response	Number of responses	Percentage 2006	Percentage 2005
Yes	392	48.5%	45.6%
No	413	51.1%	54.4%
Don't know	3	0.4%	-
Total number of relevant responses	**808**		

Satisfaction Overall

Figure 8: How satisfied or dissatisfied are you with the overall services provided by City of York Council's Housing Department?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	320	36.9%	40.0%
Fairly satisfied	377	43.4%	38.5%
Neither satisfied nor dissatisfied	93	10.7%	6.6%
Fairly dissatisfied	50	5.8%	9.1%
Very dissatisfied	26	3.0%	5.8%
Total number of responses	**866**		

Figure 9: To what extent would you agree City of York Council is a good landlord?

Response	Number of responses	Percentage 2006	Percentage 2005
Agree Strongly	389	45.9%	49.7%
Agree Slightly	251	29.5%	32.5%
Neither agree nor disagree	150	17.8%	8.6%
Disagree Slightly	38	4.4%	5.2%
Disagree Strongly	20	2.4%	4.0%
Total number of responses	**848**		

Satisfaction with property and area

Figure 10: Overall, how satisfied or dissatisfied are you with your accommodation?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	426	49.4%	57.4%
Fairly satisfied	297	34.4%	30.3%
Neither satisfied nor dissatisfied	71	8.2%	3.1%
Fairly dissatisfied	44	5.2%	5.2%
Very dissatisfied	24	2.8%	4.0%
Total number of responses	**862**		

Figure 11: Do you think the number of rooms you have in your home is..?

Response	Number of responses	Percentage 2006	Percentage 2005
Too few	151	17.7%	16.5%
Too many	42	4.9%	1.8%
About right	664	77.4%	81.7%
Total number of responses	**857**		

Figure 12: How would you describe the general condition of your home at the moment?

Response	Number of responses	Percentage 2006	Percentage 2005
Very good	266	30.8%	39.2%
Fairly good	421	48.7%	39.8%
Neither good nor poor	109	12.6%	8.2%
Fairly poor	53	6.1%	9.4%
Poor	16	1.8%	3.4%
Total number of responses	**808**		

Figure 13: How satisfied or dissatisfied are you overall with the way the Council looks after the communal areas?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	105	34.2%	51.1%
Fairly satisfied	113	36.8%	23.3%
Neither/nor	41	13.4%	14.2%
Fairly dissatisfied	27	8.8%	6.8%
Very dissatisfied	21	6.8%	4.5%
Total number of responses	**307**		

Figure 14: How satisfied or dissatisfied are you with this neighbourhood as a place to live?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	292	33.7	48.0%
Fairly satisfied	361	41.7	35.8%
Neither/nor	91	10.5	5.8%
Fairly dissatisfied	80	9.3	6.6%
Very dissatisfied	42	4.8	3.7%
Total number of responses	**866**		

Figure 15: Do you think each of the following is a serious problem, slight problem or not a problem in your neighbourhood?

	Not a problem		Slight problem		Serious problem	
Year	**2006**	**2005**	**2006**	**2005**	**2006**	**2005**
Vandalism *(Base 2006:810 Base 2005:650)*	34% *(272)*	71.2% *(463)*	47% *(381)*	21.7% *(141)*	19% *(157)*	7.1% *(46)*
Graffiti *(Base 2006: 758 Base 2005:650)*	55% *(420)*	84.3% *(548)*	39% *(298)*	13.7% *(89)*	6% *(40)*	2.0% *(13)*
Dogs *(Base 2006: 778 Base 2005:650)*	46% *(354)*	76.9% *(500)*	37% (288)	17.1% *(111)*	17% *(136)*	6.0% *(39)*
Litter & Rubbish in the street *(Base 2006: 794 Base 2005:650)*	37% *(292)*	63.8% *(415)*	47% *(377)*	28.2% *(183)*	16% *(125)*	8.0% *(52)*
Problems with neighbours *(Base 2006: 779 Base 2005:650)*	64% *(503)*	81.8% *(532)*	25% *(191)*	11.4% *(74)*	11% *(85)*	6.8% *(44)*
Racial harassment *(Base 2006: 764 Base 2005:650)*	92% *(708)*	96.5% *(627)*	6% *(43)*	2.5% *(16)*	2% *(13)*	1.1% *(7)*
Noise from people *(Base 2006: 786 Base 2005:650)*	49% *(382)*	80.5% *(523)*	37% *(291)*	13.4% *(87)*	14% *(113)*	6.2% *(40)*
Noise from traffic *(Base 2006: 767 Base 2005:650)*	68% *(524)*	85.8% *(558)*	25% *(190)*	10.5% *(68)*	7% *(53)*	3.7% *(24)*
People causing damage to your home *(Base 2006: 778 Base 2005:650)*	81% *(629)*	90.8% *(590)*	15% *(116)*	6.5% *(42)*	4% *(33)*	2.8% *(18)*
Drug dealing *(Base 2006: 762 Base 2005:650)*	52% *(393)*	83.1% *(540)*	29% *(218)*	6.2% *(53)*	17% *(151)*	8.8% *(57)*
Other crime *(Base 2006: 761 Base 2005:650)*	50% *(380)*	86.8% *(564)*	30% *(277)*	9.7% *(63)*	14% *(104)*	3.5% *(23)*

Figure 16: How satisfied or dissatisfied are you with the overall maintenance of the grounds in outdoor communal areas?

Response	**Number of responses**	**Percentage 2006**	**Percentage 2005**
Very satisfied	89	31.2%	34.2%
Fairly satisfied	102	35.6%	42.5%
Neither/nor	46	16.2%	11.5%
Fairly dissatisfied	21	7.5%	8.2%
Very dissatisfied	27	9.4%	3.7%
Total number of responses	**285**		

Figure 17: Have you or members of your household personally experienced nuisance or disturbance from your neighbours in the last twelve months?

Response	**Number of responses**	**Percentage 2006**	**Percentage 2005**
Yes	141	16.4	17.8%
No	718	83.6	82.2%
Total number of responses	**859**		

Figure 18: Thinking about how the department responded, how satisfied or dissatisfied were you with the action taken?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	17	12.6%	8.5%
Fairly satisfied	27	20.0%	23.7%
Neither/nor	21	15.5%	11.9%
Fairly dissatisfied	27	20.0%	16.9%
Very dissatisfied	43	31.9%	39.0%
Total number of relevant responses	**135**		

Figure 19: Taking into account your home and the services your landlord provides, do you think that the rent for this property represents good or poor value for money?

Response	Number of responses	Percentage 2006	Percentage 2005
Very good value	267	31.4%	34.8%
Fairly good value	363	42.8%	41.7%
Neither good not poor	148	17.4%	10.8%
Fairly poor value	56	6.6%	8.6%
Very poor value	15	1.8%	4.2%
Total number of responses	**849**		

Contact with landlord

Figure 20: Have you been in contact with your landlord in the last 12 months?

Response	Number of responses	Percentage 2006
Yes	510	60.1%
No	302	35.6%
Can't remember	36	4.3%
Total number of responses	**848**	

Figure 21: What did you last contact the housing department about?

Response	Number of responses	Percentage 2006	Percentage 2005
Repairs	310	66.2%	72.0%
Rent/housing benefit	64	13.6%	5.6%
Transfer/exchange	13	2.8%	4.6%
Neighbours	46	9.8%	2.3%
Other	33	7.0%	15.4%
Can't remember	3	0.6%	-
Total number of relevant responses	**469**		

Figure 22: Was getting hold of the right person…?

Response	Number of responses	Percentage 2006	Percentage 2005
Easy	310	61.0%	73.8%
Difficult	121	24.0%	18.1%
Neither	61	12.1%	4.9%
Can't remember	13	2.6%	3.1%
Total number of relevant responses	**505**		

Figure 23: Did you find the staff were…?

Response	Number of responses	Percentage 2006	Percentage 2005
Helpful	408	80.9%	81.4%
Unhelpful	31	6.2%	11.1%
Neither	60	11.9%	4.7%
Can't remember	5	1.0%	2.7%
Total number of relevant responses	**504**		

Figure 24: And were they…?

Response	Number of responses	Percentage 2006	Percentage 2005
Able to deal with the problem	384	76.7%	74.0%
Unable to deal with the problem	71	14.1%	16.1%
Neither/no opinion	38	7.6%	6.6%
Can't remember	8	1.6%	3.3%
Total number of relevant responses	**501**		

The repairs service

Figure 25: Generally, how satisfied or dissatisfied are you with the way your landlord deals with repairs and maintenance?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	323	38.4%	41.7%
Fairly satisfied	347	41.2%	34.8%
Neither satisfied nor dissatisfied	58	6.9%	5.3%
Fairly dissatisfied	75	8.9%	9.6%
Very dissatisfied	39	4.6%	8.6%
Total number of relevant responses	**842**		

Figure 26: And have you had any repairs completed in the last 12 months?

Response	Number of responses	Percentage 2006	Percentage 2005
Yes	545	68.0%	87.9%
No	256	32.0%	12.1%
Total number of relevant responses	**799**		

Figure 27: Thinking about your last completed repair, how would you rate it in terms of . . .?

	Very satisfied		Fairly satisfied		Neither satisfied nor dissatisfied		Fairly dissatisfied		Very dissatisfied	
	2006	2005	2006	2005	2006	2005	2006	2005	2006	2005
Being told when workers would call	53.6 %	70.0 %	27.2 %	19.4 %	6.4%	2.0%	7.2%	4.0%	5.7%	4.6%
Time taken before work started	40.7 %	63.3 %	37.2 %	22.1 %	8.5%	2.9%	7.1%	6.3%	6.5%	5.4%
Speed with which work was completed	56.6 %	72.1 %	30.9 %	16.8 %	7.2%	3.1%	3.1%	5.1%	3.1%	2.8%
Attitude of workers	65.3 %	79.8 %	26.1 %	15.0 %	6.1%	2.3%	0.6%	1.7%	2.0%	1.1%
Overall quality of repair work	55.4 %	72.9 %	28.3 %	16.0 %	7.9%	4.3%	3.8%	4.0%	4.6%	2.9%
Keeping dirt & mess to a minimum	57.5 %	74.8 %	28.5 %	18.1 %	8.3%	2.9%	3.1%	2.0%	2.5%	2.3%

Communication

Figure 28: Generally, how good or poor do you feel the Housing Department is at keeping you informed about things that might affect you as a tenant?

Response	Number of responses	Percentage 2006	Percentage 2005
Very good	302	35.4%	30.4%
Fairly good	344	40.3%	47.0%
Neither good nor poor	146	17.1%	10.4%
Fairly poor	41	4.8%	5.6%
Very poor	21	2.4%	6.7%
Total number of relevant responses	**854**		

Figure 29: How satisfied or dissatisfied are you with the extent to which the Housing Department finds out your views?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	200	23.4%	19.6%
Fairly satisfied	343	40.3%	45.1%
Neither satisfied nor dissatisfied	229	26.9%	17.4%
Fairly dissatisfied	59	6.9%	10.2%
Very dissatisfied	20	2.3%	7.7%
Don't know/no opinion			-
Total number of relevant responses	**851**		

Figure 30: Thinking about the housing services that your landlord provides, how satisfied or dissatisfied are you with the opportunities for participation in management and decision-making?

Response	Number of responses	Percentage 2006	Percentage 2005
Very satisfied	121	18.4%	15.3%
Fairly satisfied	252	38.3%	39.7%
Neither satisfied nor dissatisfied	208	31.6%	27.4%
Fairly dissatisfied	53	8.1%	7.1%
Very dissatisfied	24	3.6%	10.4%
No opinion			-
Total number of relevant responses	**658**		

Figure 31: Thinking about the most recent issue of 'Streets Ahead' that you have seen, would you say you . . ?

Response	Number of responses	Percentage 2006	Percentage 2005
Read all or nearly all of it	265	33.2%	50.5%
Read most of it	235	29.4%	20.3%
Read a few articles	124	15.5%	14.0%
Just glanced through it	141	17.6%	10.8%
Never read it	34	4.3%	4.4%
Total number of responses	**799**		

Improving services

Figure 32: Of these services, which do you consider to be the three most important?

Response	Number of responses	Percentage 2006	Percentage 2005
Keeping tenants informed	395	45.0%	49.2%
Overall quality of your home	513	58.4%	74.3%
Taking tenants' views into account	321	36.6%	40.4%
Repairs and maintenance	701	79.8%	84.3%
Involving tenants in the management of their housing	96	10.9%	7.4%
Value for money for your rent	438	50.0%	43.4%
Total number of respondents	**878**		

Figure 33: Still looking at this list of services, how much do you think each needs improving?

	No improvement need		Some improvement needed		Much improvement needed	
	2006	**2005**	**2006**	**2005**	**2006**	**2005**
Keeping tenants informed	26%	39%	39%	42%	10%	14%
Over quality of your home	25%	46%	39%	35%	12%	17%
Taking tenants' views into account	16%	39%	37%	42%	17%	14%
Repairs and maintenance	32%	56%	36%	25%	13%	17%
Involving tenants in the management of their housing	18%	50%	32%	22%	11%	8%
Value for money for your rent	36%	55%	25%	28%	10%	10%

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CS2274

Meeting of the Executive Members for Housing and Adult Social Services and Advisory Panel **15th January 2007**

Report of the Director for Housing and Adult Social Services

Long Term Commissioning Strategy for Older People in York

Summary

1. This report informs the Executive Members for Housing and Social Services and the Advisory Panel of the development of a long term (10-15 year) commissioning strategy for older people and seeks agreement to the framework for the development and delivery of this strategy.

2. In particular Members are asked to agree to agree that the strategy is developed further, in consultation with all stakeholders, to produce an implementation plan with clear objectives for reshaping services, initially for the next 3-5 years, supported by a financial commissioning plan.

Background

Strategic context

3. A long term commissioning strategy for older people has been developed with the support of the Department of Health's Better Commissioning Learning Improvement Network, with input from the Institute of Public Care at Oxford Brookes University. Three local authorities took part in the project to develop long term commissioning strategies – City of York Council, North Yorkshire County Council and Leeds City Council.

4. There is a growing emphasis on the strategic commissioning role of both local government and health agencies. Changing services takes time; time to plan; to identify investment opportunities and funding; and time to develop new models and pathways. If we can identify now the changes needed over the next 10-15 years, we can produce the required financial plan to achieve these, give clearer messages to providers to enable them to take up the challenge. And we can plan with older people how they can continue to shape the services for the future.

5. We are now at a watershed, with a need to address an anticipated large increase in demand for support by older people, and an opportunity through the framework provided by the Government's White Paper 'Our health, our care, our say'. This strategic Commissioning strategy will put us in a position to work with our partners to address these challenges.

6. A recent CSCI publication 'Relentless Optimism: Creative Commissioning for Personalised Care' says, "Commissioning is at the heart of effective social care. It offers the opportunity to transform people's lives through better services"

7. We know that nationally and locally the proportion of the population aged over 65 will increase dramatically over the next 15 years. Older People are living longer, staying active for longer, and making the most of the opportunities of age.

8. But with even higher increases in the numbers of older people over 85, we can expect a greater number of people will need care and support as they do become more frail. We also know that funding for care services is not likely to grow at the same rate as the population growth.

9. Aspirations about the way of people want to be helped are already changing. Older people will expect to have more choice, they will want to take more control than they currently have, and will expect services to support them to remain independent and healthy and active in their community. This, combined with the pressure that the growing population will put on the public purse, means that we must find the most efficient and effective ways to deliver the care and support that will be needed.

10. The Government's White Paper 'Our health our care our say' (2006) reinforces what older people have been telling us for some time. The White Paper sets a new direction for community health and social care services to offer more choice, flexibility and independence. The goals of the White Paper are not exclusively for older people's services but they should underpin this commissioning strategy, and will provide a good framework against which to reshape services.

    - Better prevention and early intervention for improved health, independence and well being
    - More choice and a stronger voice for individuals and communities
    - Tackling inequalities and improving access to services
    - More support for people with long term conditions

11. The Government has been clear that the aims of the White Paper cannot be achieved overnight but has set out in 'Our health, our care, our say: making it happen' a 'road map', which shows what implementation of the White Paper will look like. For older people's services this road map includes:

    - A reduction in the prevalence of damaging underlying determinants of health (e.g. smoking and obesity) and associated service usage.
    - A shift in resources and in planning emphasis to prevention and early intervention, supported by robust cost-benefit analysis
    - Increased self care and condition management among service users
    - More people who need care being supported to live in their own homes
    - Service users and their carers having more say over where how and by whom their support is delivered and better access to information that helps them make choices about this

- Individuals and their communities being able to influence the shape and delivery of local services and to trigger action to look at problems
- People using services being more satisfied with their overall experience of care
- More services provided in the community through:
  - Promoting emotional health and well being and preventing physical and mental illness
  - Appropriate support on discharge form hospital
  - Better support at home, using new technologies to prevent unnecessary admissions to residential or hospital care
  - More services moving out of acute hospitals
- Improved range of services for urgent care
- Local health and social services communities working together to understand and address inequalities.

12. In 2005 the Older People's Strategy 'Never Too Old' was developed jointly between the Older People's Partnership Board, City of York Council and Selby and York Primary Care Trust. The strategy sets out priorities for older people locally. It anticipated, and reflects, the national agenda in the themes and outcomes that older people in York want to see:
    - Power and Control
    - Staying Healthy
    - Independence
    - Planning for the Future.

13. There are specific objectives in the Local Area Agreement relating to Healthy Communities and Older People. These are to:
    - Reduce inequalities in health and the determinants of health;
    - Reduce the incidence/impact of CHD, respiratory disease and cancer;
    - Reduce the number of people who smoke;
    - Improve the overall physical activity level within the city;
    - Reduce levels of obesity
    - Help more older people to live independently in their own home;
    - Reduce the number of falls suffered by older people;
    - Increase the number of carers who are supported by statutory and voluntary agencies

Development of the commissioning strategy

14. Strategic Commissioning is an approach that looks at the whole needs of the local population and the services that are available to meet these needs. It seeks to forecast future demand for services and identify the gaps in the services and processes to meet these future demands. It looks at how a range of different investments and influences could be brought to bear to benefit the population. Strategic commissioning works at a higher level than traditional commissioning activity, but will be supported and delivered through more traditional, detailed commissioning plans.

15. To date we have been able to undertake a review and analysis of information on needs. This includes demographic information available from census data;

prevalence and incidence of key health conditions, available from local and national public health reports; and information about the customers we know and their assessed needs for current services.

16. We have also reviewed the information on current services, looking at quantity, cost and quality issues. Our information is best for the services we directly fund.

17. We have looked at demand forecasting and we have begun to analyse the gaps that we can anticipate as a result of the expected future demand and the aspirations of older people, against the service pattern from which we are starting. Some of this work has been less robust than we would have liked, as it became clear that our information is not robust in some areas of the analysis. However there are already some good indications of where there will be 'hotspots' if we continue with our current service models, as well as clear indications of where we need to improve our understanding of issues.

18. This is not yet a joint commissioning strategy with local health services. It has been developed in consultation with the Selby and York Primary Care Trust (PCT), but commissioning strategies and plans have continued to be developed in parallel to date. The restructuring of the PCT to form a new North Yorkshire and York PCT has meant that there has been a period where engagement from the health commissioners has been difficult. It is hoped this will change, with the appointment of new Directors at the PCT. National guidance on a joint commissioning framework for health and social care was issued for consultation in December 2006, and this will be a key item for discussion and agreement with the Directors in the new North Yorkshire and York Primary Care Trust. There are potentially many benefits that can be gained for a more joined up approach to commissioning. Ill health and disability are key factors in social exclusion and the need for people accessing social care services, and delivery of the White Paper outcomes will not be possible without more integrated working

19. Within the strategy there are information gaps, which will require us to think about what information we collect and how we can improve on this.

20. Further work is needed to define more fully the likely volumes and locations where services are needed. Funding opportunities and costs will need to be detailed in order that implementation plans can be proposed to develop the service changes that are required. Further work is also needed to ensure that the outcomes we seek to deliver are reflected in the way we specify, contract for, and monitor, services.

21. Procurement of services for those that we have responsibility for is just one part of commissioning services for the community. We will also need to look at how we influence and support the development of the right services beyond this. Universal services can be made more accessible and responsive to older people's needs. Community and voluntary services can provide a range of support and opportunity for engagement. Housing options need to be available across all tenures

Consultation

22. This strategy has drawn heavily on the vision and outcomes agreed through a Joint Older People's Strategy, 'Never Too Old', drawn up by the Older Peoples' Partnership Board in 2005. The joint strategy was drawn up with extensive consultation with and involvement from the Older People's Assembly in York.

23. Further consultation has been undertaken in the needs and service mapping analysis with both the Older People's Assembly representatives, and with other stakeholders. This has included:

    - Representatives of private and voluntary sector provider organisations
    - CSV York
    - Selby and York Primary Care Trust (prior to reorganisation)
    - Selby and York Mental Health team

24. All stakeholders have been very positive about the development of the strategy and are keen to influence it as it develops. The messages that have emerged so far have been shared and have met with general approval and interest.

25. There are plans to involve all of these stakeholders in the more detailed work needed to develop a way forward and an initial 3-5 year implementation plan.

26. Consultation with customers is one of the areas that the analysis so far has identified will need to be improved. Whilst we do survey and record customers and carers feedback on services we do not yet have a robust approach which can help us identify if there are any areas where services or responses could be changed to deliver better outcomes.

Options

27. **Option 1** - Would be to aim to continue providing services in the same way, but increase capacity and funding to meet growing demand. This option is unlikely to meet the challenges of the Government's White Paper, and is unlikely to meet the vision contained within the joint strategy for York Never Too Old. It is unlikely that funding will increase in line with demographic growth to make this option affordable.

28. **Option 2** - Alternatively we should embark on a longer-term programme to reshape services and to target interventions where they are most needed and most effective. This will include a new emphasis on prevention and inclusive services, which offer control and choice and which allow statutory services to focus on those with the most complex needs.

29. Specifically work will be needed to:

    a) Develop a joint commissioning framework with the Primary Care Trust, aimed at providing services and interventions that will allow greater integration and links with PCT services. This will probably be around GP surgeries and community health localities and will include long term conditions, rapid response and out of hours services.

b) Work with users and carers, and providers in the private and third sector to agree a way forward and develop a commissioning plan for the next 3-5 years.

c) Progress with the agreed Accommodation and Support Strategy and the Older People's Housing Strategy to ensure best use is made of current resources, and housing choices continue to be increased including for owner occupiers.

d) Develop the use of Assistive Technology and explore ways to maximise its use with the Primary Care Trust to offer older people more independence and dignity, and release resources from current health and care provision and thus create capacity to meet growing demand.

e) Develop a Prevention strategy that will look at how community networks and universal services can be developed and supported to reduce isolation, enable access to practical support and ensure that new care delivery models, such as Assistive Technology, do not leave people without company and social interaction, To ensure good signposting and access to preventive services, which can help improve and sustain health and well-being.

f) Develop commissioning and contracting arrangements that will focus on outcomes for customers and deliver new models of care that are compatible with the use of individual budgets or Direct payments

g) Working in partnership with residential and /nursing providers to ensure a secure market.

30. Key challenges in achieving this will be to provide imaginative and flexible support to ensure that carers are helped to continue supporting friends and family, and to develop services that can better support older people with dementia to remain longer in their own homes.

Analysis

Key messages from needs analysis

31. We can expect the population of people over 65 in York to grow by 31% over the next 15 years, an additional 9540 people over 65 by 2020. Of these 4644 will be over 75.

32. Dementia will affect around 700 more people within the next 15 years.

33. Physical and sensory disabilities can be expected to affect an additional 6,000 people within the next 15 years.

34. We currently offer social services to around 40% of the population expected to have a physical disability, and around 14% of those with dementia, based on prevalence rates. If our current service provision continues at the same level these increases in population and associated needs will mean an additional 105

people could require services because of dementia, and an additional 2322 because of disability by 2020. Around 433 of these additional customers could need residential or nursing care, based on our current service delivery ratios.

35. If we were to continue providing the current pattern of community based and residential and nursing home care services to the increasing numbers of older people the additional costs to the Council would be £7m per annum by 2020 – an increase on the expenditure in 2005/6 of 43%.

36. An analysis of the reasons why older people were considered as needing residential and nursing care over the last two years shows that the highest number were because of dementia and confusion (31%). 15% needed care following a stroke, 11 % because they were falling at home. 6% were diagnosed with Parkinson's disease and 6% were experiencing serious anxiety or depression. Any plans to keep more people at home for longer will need to look at how these needs can be better met within the community.

Key messages from service mapping

37. We have a good range of popular preventive services in the City, provided mainly by the voluntary sector. Continuity of funding is an issue for many of these services. The lack of a Prevention Strategy means that sustainability; equitable access and capacity issues are not addressed systematically.

38. Extra Care developments have helped to reduce the numbers needing residential care, but these developments have so far been primarily in Council owned stock. There are areas of the city with high numbers of older people and no local extra care resource, and the options for owner-occupiers are very limited.

39. We believe that our new model for domiciliary care services will release capacity and funding, and ensure that older people are helped wherever possible to regain self care skills and independence but receive a service best suited to their needs if they need long term personal care.

40. Intermediate Care bed provision is set to reduce over the next year, but together with the transitional care beds the service has contributed to very low levels of delayed discharges from the acute hospital. Further work is planned with the PCT look at both step up and step down services.

41. Older Peoples' mental health services are not yet configured in the most effective way to deliver community based care and support, nor to make best use of the resources invested in mental health services.

42. Whilst the flexible carers budget is proving very successful there is still a lot of work to do to ensure that carers' needs are understood and met. If we do not do this we risk not supporting as many older people as possible to stay in their own homes for as long as possible.

43. Demand for, and capacity within, the residential care sector is reducing. The pressures within the sector are for EMI vacancies, and 'High Dependency'

residential care, and this is where City of York Council have been focussing development of their role within the market. A high proportion of those needing residential or nursing care are self funders (around two thirds).

44. All services are already struggling to recruit and retain staff, and this is likely to continue to be the case.

Corporate Objectives

45. The development of a long term commissioning strategy for older people will help to deliver five of the Council's 13 priorities:

- Improve the health and lifestyles of the people who live in York, in particular among groups whose levels of health are the poorest.
- Improve the quality and availability of decent affordable homes in the city
- Improve our focus on the needs of customers and residents in designing and providing services
- Improve the way the Council and its partners work together to deliver better services for the people who live in York
- Improve efficiency and reduce waste to free-up more resources

Implications

46. The commissioning strategy will have the following implications:

Financial

47. There are no immediate financial implications at this stage of the strategy development. The following table however summarises the financial implications of the growth in numbers of older people should service models stay the same as they are currently. This does not allow for inflation or any additional real term costs to provide services, such as those assumed in the Wanless report of 2005 'Securing Good Care for Older People', which suggested there will be a real term annual increase of 2% in the costs of services for older people over this period.

Service	**Customers supported 2004/ 2005**	**Cost £m**	**Projected customers 2020**	**Projected cost 2020 £m**
Home care	2120	6	3108	8.9
Residential/nursing care	995	9.5	1428	13.6
Total	**3135**	**15.5**	**4536**	**22.5**

48. If services are to be reshaped in line with the objectives of the White Paper and the local strategy Never Too Old there will be future proposals to release and reinvest current investments to develop new services. If Members agree to the further development of the strategy it is proposed that a more detailed financial plan will be produced by the summer 2007.

Human Resources (HR)

49. There are no immediate HR implications. If services are to be reshaped there may be HR issues in the future. These will be identified and addressed once an Implementation Plan is developed.

Equalities

50. The Commissioning Strategy will have at its heart a need to ensure equitable access to services for all older people. The strategy specifically looks at the needs of older people with a disability, who, with their carers, are most likely to need the support of social care services. More choice and control will ensure individual needs and preferences can be better provided for. This will be the same for elders from ethnic minority groups, where the numbers in any one group are still low and not suggesting the need for specific services for any one community. Population changes will need to be monitored over the next 15 years, to identify if this position is changing over time.

Legal

51. There are no legal implications

Crime and Disorder

52. Older people often fear crime. There are no specific recommendations at present with respect to this, but it is anticipated that the development of a preventive strategy and support will help to address these fears and enhance well-being.

Information Technology (IT)

53. It has become clear during the development of the strategy that we and many other local authorities do not currently collect and analyse information in a way that best supports strategic commissioning needs. This is part of the reason why there are some gaps in the information within both the needs and the services analyses. In preparation for the implementation of the new Social Care Information system work is planned to look, with the Institute of Public Care, to identify the commissioning information requirements so that new IT systems can better address these.

54. As the strategy is developed and delivered there will be new information requirements. Greater integration with health services will require more information sharing. This is already identified within the Department's IT strategy. Information sharing arrangements for preventive services will need to be explored.

55. As service models are reshaped there will be further impacts on the information systems. These will need to be scoped as change is planned and implemented.

Property

56. There are no property implications

Other

57. There are no other implications at this stage in the strategy development

Risk Management

58. The growth in numbers of older people bring significant risks in relation to both the capacity to meet the needs of those who require support and care, and the costs of doing so.

59. Option 1 (maintaining current service models and increasing capacity) will do little to manage these risks, and we would need to plan to source and fund the additional care for over 2400 additional individuals at a potential cost of an additional £7m. With workforce pressures not expected to ease, this is unlikely to be feasible. Further risks would be that the Council would fail to meet future Government targets, in line with the White Paper objectives, and the pressure on the health service will also be unsustainable. Planning to address these issues on a traditional 3-5 year cycle could address some of the issues as they arise, but would mean that opportunities for change may be lost and responses will be more reactive to actual problems and less effective.

60. Option 2 (developing a long term strategy) offers more opportunity to manage the risks. Capacity and costs are still likely to grow, but if services are reshaped and aligned with health provision there will be a greater opportunity to reduce the level of dependency on the most costly services for complex needs, as well as to maximise people's independence. There is a risk that the delays in being able to engage the PCT will reduce the opportunities for joint commissioning of services, and there are risks that our current information does not fully allow us to understand the demands, or to shape the way the market develops. These risks can be managed by ensuring action is taken now to address both issues.

Recommendations

61. That the Advisory Panel recommend the Executive Members to agree Option 2 which recommends embarking on a longer-term programme to reshape services for older people in York and to target interventions where they are most needed and most effective.

62. Reasons:

i) Government messages are clear that strategic commissioning should become a core activity for both local authorities and health.

ii) There will be major challenges in the next 15 years to meet the needs and aspirations of the growing older population in York.

iii) Government policy and local strategy has identified that the current service models need to change to meet these major challenges.

iv) It is essential that we engage user and carers, providers and other stakeholders in identifying the way forward and the long term commissioning strategy will help that dialogue develop.

Contact Details

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554143	**Report Approved** √ *29/12/06*

Specialist Implications Officer(s)

Financial	*IT*
Debbie Mitchell	*Phyllis Wicks*
Head of HASS Finance	*Information Management and IT Manager (HASS)*
554161	*554077*

Wards Affected: *List wards or tick box to indicate all* **All** √

For further information please contact the author of the report

Background Papers:

'Our health, our care, our say; a new direction for community services'. Department of Health 2006
'Our health our care our say: making it happen' Department of Health 2006
'Never Too Old' Joint Strategy for Older People York Older People's Partnership Board 2005

Annexes

City of York Council Draft Long Term Commissioning Strategy for Older People –

- Needs Analysis – Annex 1
- Service Mapping – Annex 2
- Gap analysis – Annex 3

[Please note that the above Annexes are available to view on the Council's website. Copies are available, if required, from Democratic Services – contact details at the foot of the agenda frontsheet)]

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Annex 1

DRAFT REVIEW OF DEMAND

Preamble

Over the next twenty years Britain faces major changes in the balance of its population. Already those aged over 60 outnumber those aged under 16 and by 2040 there will be 5 million more people aged over 65 than there was when the century began. These changes will mean that public services need to adapt to a different population profile and plan ahead if people are to have available the kinds of services and support that they will need and expect.

However, demographic change alone does not enable an accurate prediction of future requirements for services. As the DEMOS report, The New Old[1] states "being literate in the language of demographic change does not by itself improve our clairvoyance about the kind of society that it will help to shape". There are of course many factors that may have a profound influence on the older persons population, for example:

- Changes in wealth with a higher proportion of older people having occupational pensions and equity via their past purchases of property.
- Changes in the ethnicity of the population meaning different types of service may be requested.
- Improved health through drug treatments and new surgical interventions.
- Poorer health due to obesity and stress.
- Changes in the role of local authorities from direct providers to facilitators of provision.

Therefore, whilst the impact that demographic change may have is not entirely predictable it is equally unfeasible for local authorities to simply be reactive to demand when it occurs. Such an approach would only be likely to mean short term, high cost, decision making, a flight of capital from public into private provision and a shortfall of services when most needed as local authorities try to meet rising demand.

This document is a first attempt to address thinking with regard to future provision. It aims to explore the potential needs of the population, demand for and supply of

[1] The New Old: Why baby boomers wont be pensioned off, Huber and Skidomore 2003

services, analyse gaps in provision and look at how those may be addressed over the next ten years.

Needs Analysis

Our understanding of future demand is presented under the four headings:

- Population needs assessment/Population Profiling – An understanding of need based on the assumption that the presence of certain characteristics or conditions is a potential indicator of demand for services.
- Surveys of anticipated future need – This looks at need based on the assumption that people know what they want now and in the future.
- Service user profiling – Assumptions about need are based on the current response to services to meet identifiable demand multiplied by changes in the population.
- Analysis of met, but unsatisfied demand – This more complex aspect of need looks at where services are provided but it does not seem to deliver the outcome required or deliver the benefit the service user anticipated.

1. Population needs assessment/Population Profiling

The 2001 Census reported the total population of York to be 181,053, 34% of which were over the age of 50. 19.4% (35,185) of the population were of pensionable age compared to 13.6% in England and Wales. Map 1 illustrates the demographic breakdown of people of pensionable age by ward.

1: Number of residents in York over the age of 50

Age	Number of residents	% of residents
50-64	**31,475**	**17.4**
65-74	**15,804**	**8.7**
75 and over	**14,756**	**8.1**

Source: NOMIS (Census Tables T05 & T06)

In the above table the 50-64 age group has been included to highlight the post retirement population that will increase over the next twenty years. This is further illustrated by Subnational Population Projections (see table 2), which predicts a growth of 31% by 2020 of the population aged over 65

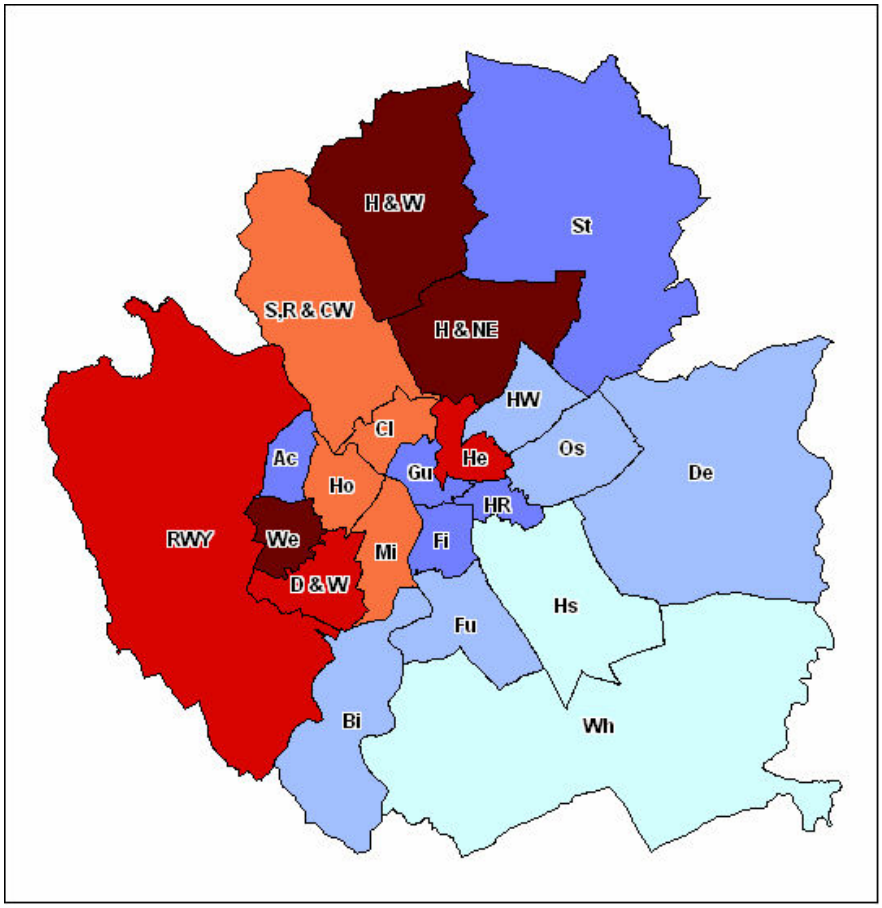
Table 2: Projected number of residents in York, in 000's between 2007 and 2020

AGE GROUP	2007	2010	2015	2020
65-69	8.3	8.8	11.2	10.1
70-74	7.6	7.9	8.3	10.5
75-79	6.5	6.6	7.1	7.5

80-84	5.0	5.1	5.4	5.9
85+	4.3	4.7	5.3	6.0
Totals	31.7	33.1	37.3	40.0

Source: Office of National Statistics

Map 1: Number of people of pensionable age



Wards

Acomb (Ac)
Bishopthorpe (Bi)
Clifton (Cl)
Derwent (De)
Dringhouses & Woodthorpe (D&W)
Fishergate (Fi)
Fulford (Fu)
Guildhall (Gu)
Haxby & Wigginton (H&W)
Heslington (Hs)
Heworth (He)
Heworth Without (HW)
Holgate (Ho)
Hull Road (HR)
Huntington & New Earswick (H&NE)
Micklegate (Mi)
Osbaldwick (Os)
Rural West York (RWY)
Skelton, Rawcliffe & Clifton Without (S,R&CW)
Strensall (St)

Number of people of Pensionable Age (Total per Ward)

2,560 to 3,010 (3)
2,090 to 2,560 (3)
1,620 to 2,090 (4)
1,150 to 1,620 (5)
680 to 1,150 (5)
210 to 680 (2)

In terms of life expectancy women have a greater life expectancy than men (80.5 years compared to 75.9 years). Consequently:

- On average women aged 65 can expect to live to the age of 84, men to the age of 81[2]
- A 75 year old woman can expect to live for another 12 years (to 87) and a 75 year old man can expect to live for another 10 years (to 85) and a.[3]

The 2001 census shows that within the over 65 population 33% (11,688) were identified as living alone. The distribution of older people who are living alone is similar to the overall distribution, with Haxby and Wigginton, Huntington and New Earswick, Westfield Heworth, and Micklegate all having high numbers of lone pensioners

Ethnicity

The ethnic breakdown of York residents over the age of 50 indicates a black and minority ethnic population of 1,756, which equates to 1% of the total population and 2.8% of the population aged over 50.

Table 3: Breakdown for BME residents of York over the age of 65

Age	Number of residents	Proportion of age group (%)
65-74	371	2.3
75 and over	342	2.3

Source: NOMIS (Census Table T13

There is no one significant community of BME older people within York. The biggest groups are White Irish (301) and White Other (278). The next largest groups are Chinese (40) and then Indian (29).

[2] Office of National Statistics

[3] Ageing, Scientific Aspects (House of Lords, 2005)

Mid year estimates indicate that ethnic minority population is growing within the city, with the biggest changes (numerically) in the White Other, Asian or Asian British Indian and Asian or Asian British Pakistani populations. Over the next 15 years we will need to keep the size and needs of the older BME populations under review.

Tenure

Nationally, over the last fifty years, the proportion of older people who own their home has increased dramatically. City of York has 78% home ownership compared to a 68% national average. This suggests that substantially more older people in York are 'asset rich' compared to their peers in other parts of the country, and potentially have the equity to fund care needs, or to purchase specialist housing.

Table 4: Breakdown of older people's tenure

Percentage of older people living in particular types of housing tenure			
Owned	**Rented from the local authority**	**Other social rented**	**Private rented & living rent free**
78%	12%	6%	4%

Source: NOMIS (Census Table SO17)

The percentages vary across the wards in the city, between 98% owner occupiers in Heworth Without, to 44% in Guildhall. Guildhall, Westfield, Heworth, Clifton and Micklegate wards all have 30% or more of their older population living in social rented accommodation (Council or other Registered Social Landlords), which suggests that the older people living in these wards are likely to be less affluent than those in wards with higher levels of owner occupation

Central heating

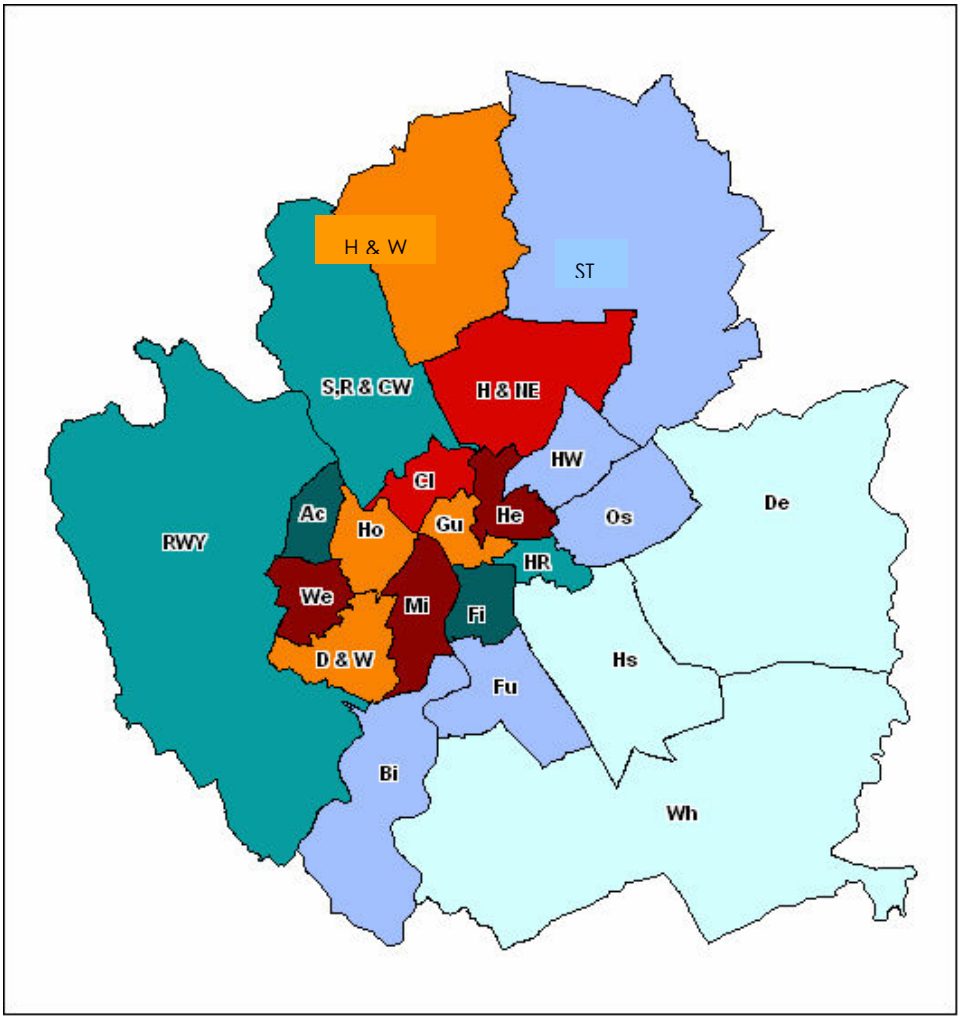
The absence of central heating can be an indicator of poverty, and of increased risk of ill health. 10% of households with people of pensionable age do not have central heating. Proportions tend to increase with age reflected by the fact that 18% of those over 85 live in accommodation without central heating, with the highest concentration being in the wards of Micklegate, Holgate, Clifton and Heworth.

Access to a car

Lack of access to a car is one way that older people can be socially excluded within their communities. Particularly for those with mobility problems, no access to a car will limit access to community facilities and social activities.

Over 50% of pensioner households in Micklegate, Guildhall, Heworth, Clifton and Westfield do not have access to a car. Map 2 shows the actual numbers of households across the city who do not have access to a car.

Map 2: Pensioner households that do not have access to a car



Households (aged over 65) that do not own a car (total per ward)

798 to 922	(3)
673 to 798	(2)
548 to 673	(4)
423 to 548	(2)
298 to 423	(3)
173 to 298	(5)
48 to 173	(3)

Wards

Acomb (Ac)
Bishopthorpe (Bi)
Clifton (Cl)
Derwent (De)
Dringhouses & Woodthorpe (D&W)
Fishergate (Fi)
Fulford (Fu)
Guildhall (Gu)
Haxby & Wigginton (H&W)
Heslington (Hs)
Heworth (He)
Heworth Without (HW)
Holgate (Ho)
Hull Road (HR)
Huntington & New Earswick (H&NE)
Micklegate (Mi)
Osbaldwick (Os)
Rural West York (RWY)
Skelton, Rawcliffe & Clifton Without (S,R&CW)
Strensall (St)
Westfield (We)

Mental Health: Dementia

The Audit Commission report, *Forget Me Not*, (published in 2002), estimated the prevalence rates for dementia and clinical depression. It stated that for dementia the prevalence rate was 6% for those aged 75-79, 13% for those aged 80-84, 25% for those aged over 85.

Based on these prevalence rates Table 5 provides an estimate of the numbers of people expected to be suffering from dementia for the next 15 years. Map 3 shows the estimated prevalence rates for dementia by ward.

In their report, Dementia North indicated that in 2002 approximately 700 elderly people with dementia were living in the community with daily care needs. Much of this care was provided on an informal basis. The Dementia North report also estimated that 210 dementia sufferers lived alone with 126 of these having no regular access to a carer.

In 2005-06 287 people over 65 who received services from the Housing and Adult Social Services Department were recorded as having primarily mental health needs due to dementia. That is 14% of the estimated total prevalence rate, and 41% of the estimated 700 people with daily care needs.

If referral rates and service provision remained constant at 14% of the total prevalence this would mean that by 2020, with a 31% increase in population we might expect to be providing services for an additional 105 customers, with around 47 needing residential or nursing home care and around 58 needing support in the community. This would mean we would be providing services to a total of 392 customers by 2020.

However, there could potentially be a further 564 people with daily care needs due to dementia, who, using this model to predict future needs, would not be known to us but receiving care on an informal basis. This would be an increase of more than 150 on the 2002 estimates of the Dementia North Report.

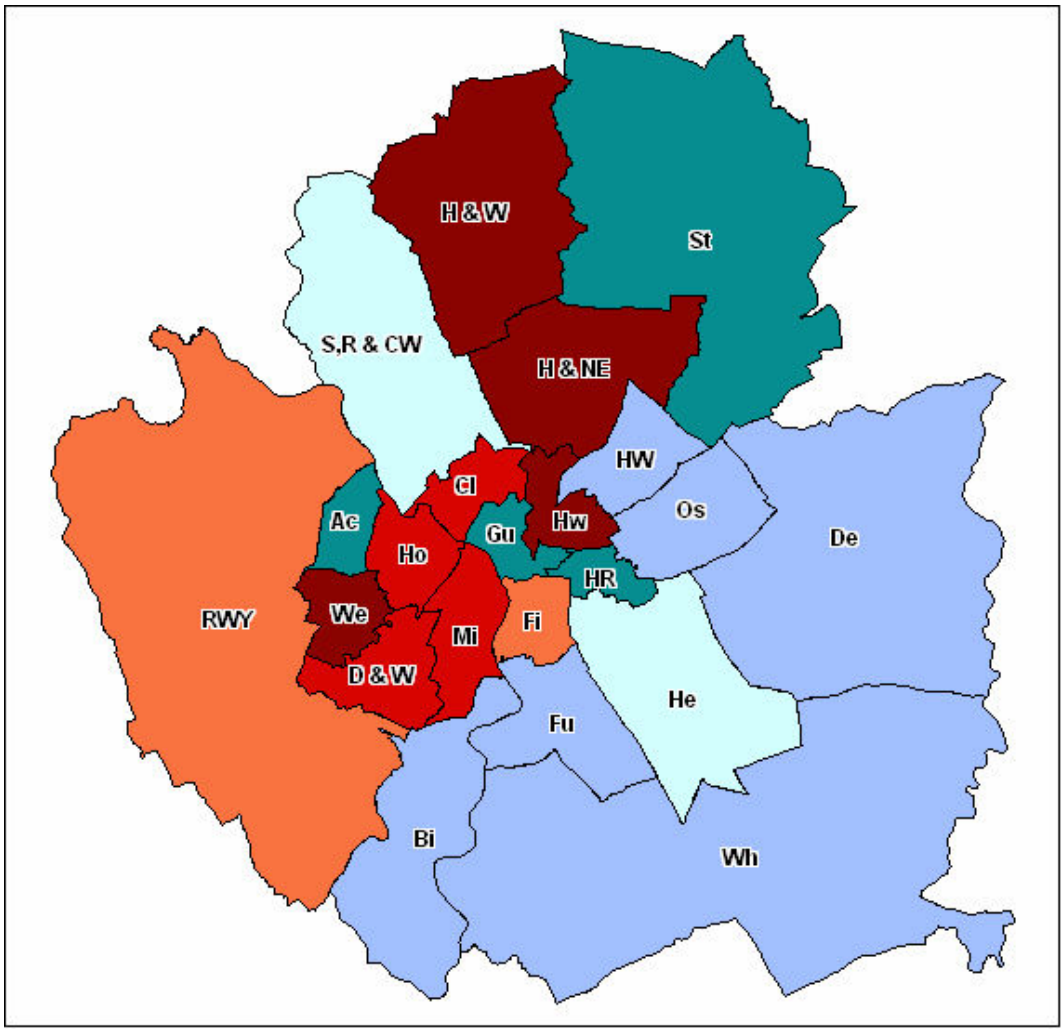
Table 5: Estimated prevalence rates for dementia in York, 2005 – 2020

Age Group	2005	2010	2015	2020
75-79	400	400	400	500
80-84	700	700	700	800

85+	1000	1200	1300	1500

Source: Forget Me Not (Audit Commission)&Subnational Population Projections(Neighbourhood Statistics)

Map 3: Estimated prevalence rate for dementia.



Dementia Prevalance for people aged over 75 (Total personsper Ward)

130 to 158	(4)
100 to 130	(4)
80 to 100	(2)
60 to 80	(4)
30 to 60	(6)
0 to 30	(2)

Wards

Acomb (Ac)
Bishopthorpe (Bi)
Clifton (Cl)
Derwent (De)
Dringhouses & Woodthorpe (D&W)
Fishergate (Fi)
Fulford (Fu)
Guildhall (Gu)
Haxby & Wigginton (H&W)
Heslington (Hs)
Heworth (He)
Heworth Without (HW)
Holgate (Ho)
Hull Road (HR)
Huntington & New Earswick (H&NE)
Micklegate (Mi)
Osbaldwick (Os)
Rural West York (RWY)
Skelton, Rawcliffe & Clifton Without (S,R&CW)
Strensall (St)
Westfield (We)

Mental Health: Depression

Forget Me Not also indicated that 10 - 16% for all those aged over 65 would be likely to suffer from clinical depression. Table 6 provides an estimate of the numbers of people expected to be suffering from clinical depression over the next 15 years. The Dementia North report of 2002 estimated a lower number of older people with depression. There estimate was a total of 3,600 with the possibility of in excess of 1,500 of these having severe depression.

Table 6: Estimated prevalence rates for clinical depression in York, 2005 – 2020

	2005		2010		2015		2020	
Age Group	Min	Max	Min	Max	Min	Max	Min	Max
65-69	900	1400	900	1400	1100	1800	1000	1600
70-74	800	1200	800	1300	800	1300	1100	1700
75-79	700	1000	700	1100	700	1100	800	1200
80-84	500	800	500	800	500	900	600	900
85+	400	600	500	800	500	800	600	1000

Source: Forget Me Not (Audit Commission)&Subnational Population

Everybody's Business (Dh/CSIP 2005) highlights the inextricable link between physical and mental health for older people. Despite the wide disparity in estimated numbers of older people with depression it is still the most common mental health problem in older age. It is further estimated that 40% of care home residents are depressed. 40% of older adults attending GP surgeries have mental health needs and for 20-25% this is the sole reason for attending. 50% of older people who are hospital inpatients are estimated to have or develop a mental health problem during their admission.

Currently, we do not specifically analyse information about the incidence of depression in our customers and so do not know if we are recognising and dealing with it appropriately. Failure to identify these needs may increase the length of stay in hospital and reduce the likelihood that a patient will return to live independently. If we can improve the way we recognise and respond to depression we will be addressing a key concern in the 'well-being' agenda for older people and potentially reduce the length of stay in hospital and attendance at GP surgeries.

Physical Health

A range of general population data is available about older people's health and well being. For example:

- Most older people die from cancer or circulatory system problems, eg, heart attack, stroke etc. However, cancer diminishes as a cause towards older old age to be replaced by respiratory problems.
- Older people with non age specific conditions such as cancer are often less likely to receive the same sorts of services. Only 8.5% of those age over 85 years dying of cancer die in a hospice compared to 20% of all cancer deaths. Older people are less likely to die at home than younger people although that is their stated preference.[4]
- Since 1980 there has been no change in older people reporting of whether they are in good health or not. 25% saying their health is not good. A third of older people report difficulties with their hearing as compared to 28% reporting difficulties with their sight.[5]
- Just under a third of all women and men aged between 55 and 74 are clinically obese.[6]
- Two-thirds of the population aged over 65 have foot problems of which a quarter of the population over 65 have problems that need professional foot care although they do not receive it.[7]
- Urinary incontinence affects some 24% of older people and between 30-60% of people in institutional care. Faecal incontinence occurs in approximately 1-4% of adults and up to 25% of people institutional care.[8]

The Health Survey of England 2001 provided a level of prevalence for five types of disability, those being:

- Locomotor (walking and using stairs)
- Seeing
- Hearing
- Communication

[4] Dying in old age, Help the Aged, Tom Owen 2005.

[5] People aged 65 and over, General Household Survey, 2001

[6] Health Survey of England 2006

[7] Best Foot Forward, Help the Aged 2005

[8] Report of National Audit of Continence Care, Royal College of Physicians, November 2005

- Personal Care (activities relating to daily living e.g. eating, dressing, toileting)

The same study also shows the differing prevalence rates between those resident in care homes and private household's.

Table 7 Comparison of disability between older people in a care home and those in private households

	Care homes	Private households
Men aged 65-79	77%	35%
Men aged 80 & over	87%	62%
Women aged 65-79	85%	35%
Women aged 80 & over	89%	64%

Consequently, we would expect that today in excess of 12,000 older people living in private households to be suffering from at least one of the five forms of disability, with the most common likely to be locomotor disability. Table 11 shows that in 2005/6 we knew of 4,698 of these (approximately 39%)

Falls

There is limited information on the impact that falls have on the demand for services locally, but the NSF for Older People (Department of Health 2001) makes it clear that falls are a major cause of disability. Even where they do not cause serious injury, falls can lead to a loss of confidence, social isolation and depression, hypothermia, pressure related injury and infection.

Tinetti et al, 1998, indicated that the prevalence of people over the age of 65 falling once was 30% of which 15% would fall more frequently. Based on this calculation Table 8 provides an estimate of the numbers of people in York and the numbers of falls they might have, over the next 15 years.

Table 8: Estimated prevalence rates for falls in York, 2005 – 2020

	2005		2010		2015		2020	
Age	1 Fall	Fall >1	1 Fall	Fall >1	1 Fall	Fall >1	1 Fall	Fall >1
65-69	2600	390	2600	390	3400	510	3000	450
70-74	2300	345	2400	360	2500	375	3200	480
75-79	2000	300	2000	300	2100	315	2300	345
80-84	1500	225	1500	225	1600	240	1800	270
85+	1200	180	1400	210	1600	240	1800	270
Total	**9600**	**1440**	**9900**	**1485**	**11200**	**1680**	**12100**	**1815**

Source: Tinetti et al, 1998 & NOMIS (Census Table T05)

Chronic Disease

Overall York has xxxx people with a limiting long term illness. Assuming all other factors remain equal this population is likely to grow to xxx by 2020. Currently, Haxby and Wigginton, Huntington and New Earswick, Heworth and Westfield also have the highest numbers of pensioners with a limiting long term illness.

This next part of the report provides an indication what is known of the type of conditions and service provision associated with chronic disease, including those conditions which have been identified above as leading to frequent hospital admissions. It is by no means an exhaustive list and we know that we have little information for any of these conditions about the way they impact on the need for services.

Diabetes

The Health Survey for England, 2003 indicated a variation in the prevalence of diabetes in relation to gender and age, this is illustrated in Table 9.

Table 9: Expected prevalence of older York residents suffering from Diabetes

Age	Gender	Number of residents	Proportion of age group (%)
65-74	Male	860	11.9
	Female	720	8.4

75 and over	Male	440	8.1
	Female	590	6.3

Source: Joint Health Surveys Unit (2004) & NOMIS (Census Table T05)

An estimated 4,600 people in the Selby and York PCT area over 60 suffer from type 1 and 2 diabetes (YHPHO). If no action is taken to reduce current and predicted levels of obesity, it is estimated that by 2010 this will have increased to 5,700. Forecasting beyond 2010 is not available at present. To counter this increase local actions have been identified to develop a primary care service model. That builds greater capacity and support to provide ongoing care management in the community. We have little information on the impact of diabetes on the need for services, but people with diabetes have a higher chance of developing certain serious health problems, including heart disease, stroke, high blood pressure, circulation problems, nerve damage, and damage to the kidneys and eyes, any of which will increase the need for help and support.

COPD

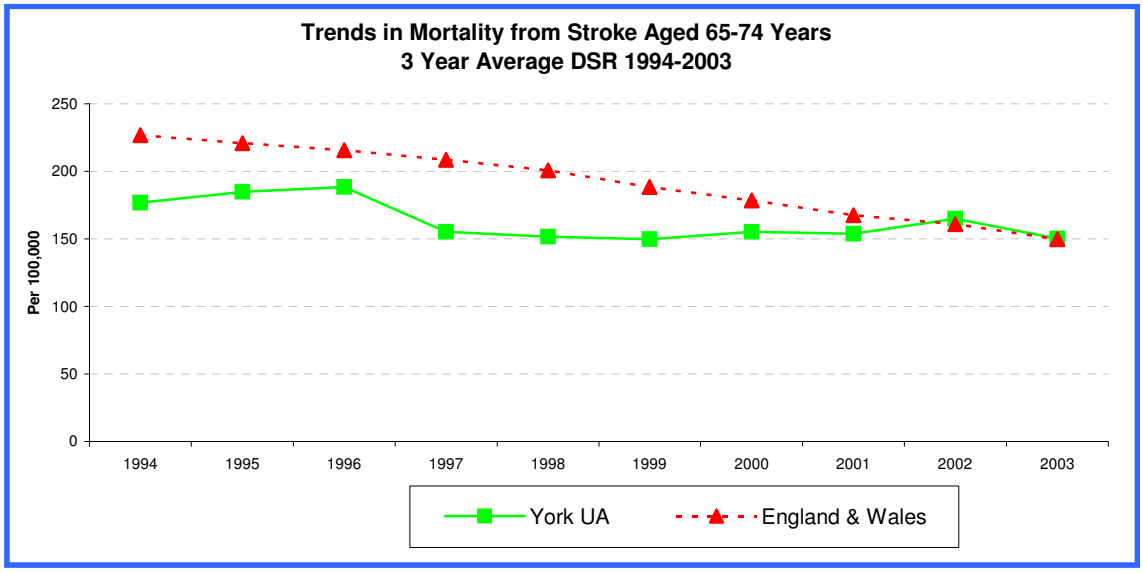
National figures from the Bandolier Journal, 2006, indicate that up to 4% of people over the age of 65 will suffer from COPD. This would equate to 1,100 York residents.

We do not have access to information about the number diagnosed with COPD, or the range of services that they receive. However in 2005/6 there were 417 admissions to the acute hospital, with this diagnosis, resulting in 3,624 bed days

Stroke

Strokes have a major impact on people's lives. 65% of surviving stroke patients can live independently after a year, but 35% are significantly disabled and 5% are admitted to long term care (NSF for Older People). Recovery can continue for several years after a stroke. The Neurological Society, 2003, stated that the expected prevalence rate for stroke was 0.5% of the population. Consequently this indicates that currently approximately 150 of York residents over the age of 65 will have suffered a stroke.

Until 1999 death rates for York residents in the 65-74 year age group due a stroke were well below the national average. However, as can be seen in the graph below, this position has worsened, with York now at the national average level. *(Please note that these are based on 3 year averages and the latest annual figures for 2004 do actually show a marked improvement i.e. 106 per 100,000 for York compared to 136 per 100,000 for England).*



Source: C&HI (ICD10 I60-I69, I69, ICD9 430-438 adjusted)

In summary, the potential increase in number of older people experiencing chronic diseases by 2020 can be predicted as follows, based on a 31% increase in population. Figures for diabetes patients has only been modelled to 2010 to date*:

Table 10: Predicted increase in chronic diseases

Condition	Current numbers	2020 predicted numbers
Diabetes	4,800	*5,700 * forecast for 2010*
Falls (more than 1 a year)	1440	1815
COPD	1,100	1604
Stroke	150	200

2. Surveys of anticipated future need

National studies

The research material below explores the results from a number of studies which look at older peoples needs, attitudes and problems. Whilst this material is not York specific there is no reason to suppose the responses of local people would be any different. Indeed the more limited local studies that have been conducted to date would look to confirm much of this material.

Attitudes to old age and quality of life

- Older people attached importance to three priorities in later life[9]:

    - Staying in their own homes
    - Good health
    - Having sufficient income to be comfortable.

- Those who experienced change in old age through moving, death of a spouse or health generated incapacity were the people most likely to shift their view of what was meant by independence. The report describes some of these key events as transitions and goes on to argue that "Given the difficulty in planning for many of the transitions associated with later life, it is important that services are targeted to meet pensioners needs at key anticipated crisis points, and that these are accessible, easy to navigate, and offer multiple points of contact - where any one agency could jumpstart the facilitation of access to a wider host of relevant services." [10]
- Infrequent social contact with people outside the household correlates with greater chances of a poor quality of life but there is little difference in frequency of contact between owner occupiers and renters.[11]
- A good quality of life for older people was identified as having good friends and neighbours, good health, happy marriage/family, being content with what you've got and having enough money. For people aged 85+ contact with other people was rated as the most important aspect of the quality of their lives.[12]
- Among people aged 65+[13]

    - 14% unable to walk down the road on their own,
    - 10% unable to manage stairs.
    - 5% unable to cook a main meal for themselves.
    - 37% live alone.

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[9] Independent living in later life Dep't Work and pensions Research report 216

[10] Ibid

[11] Inequalities in Quality of Life Among People aged 75 years and over in Great Britain. Breeze, Grundy, Fletcher, Wilkinson, Jones and Bulpitt, March 2002.

[12] Farquhar, Elderly Peoples Definitions of Quality of Life, Social Science and Medicine, 41.10 1995

[13] People aged 65 and over, General Household Survey, 2001

- 79% of older people saw a relative or friend at least once a week.
- The domestic tasks that were most likely to cause older people difficulty were those that involved climbing. Just under a third of older people were unable to perform jobs which involved climbing without help.
- The number of older people receiving help in the home has not significantly changed although there has been a substantial shift from local authority provided help to people funding their own home care. Approximately 14% of older people receive some form of paid for help in the home.[14]
- 7% of older people report that they are often or always lonely. This proportion has not substantially changed over the last 60 years. However the recent study estimates that there is under reporting in this figure.[15]
- Of the coming generation of older people (those born between 1945 and 1965 – The Baby Boomers) only 14% believe that 'in general the people in charge know best' compared to 26% of current over 65's.[16]

Funding and finance

- Over the past two decades pensioner incomes have increased twice as fast as average earnings. [17]
- Whilst older people support equity release schemes in principle older home owners are deeply reluctant to take out loans secured on their property.[18]
- People in their fifties are least supportive of passing on assets rather than enjoying them for themselves (72% -28%). The very old and the relatively young are more supportive of passing on an inheritance. However, even among the over 80's a majority say they will enjoy life rather than worry about inheritance (54%-32%).[19]

Housing Accommodation and Neighbourhoods

[14] Ibid

[15] Loneliness, Social Isolation and Living Alone in Later Life, Victor, Bowling, Bond and Scrambler ESRC, 2003

[16] MORI Social Values 1999

[17] Opportunity Age, Dept Work and pensions 2005.

[18] Joseph Rowntree Equity release 1998

[19] Attitudes towards inheritance in Britain JRF Findings July 2005

- Older people living in specialist housing schemes regard them as a place to live rather than a place to die in. They did not want to live in a place where everyone was frail.[20]
- Moving down from owner occupation during most of adult life to social sector housing carries significantly greater chance of three out of five poor outcomes. An upward move carries reduced chances of two outcomes compared with staying in the same social sector. [21]
- People in their 50's viewed staying in their own home as generally desirable. Some wanted to stay where they were whatever. Others were prepared to move house or even area, to live in an optimum environment in terms of social networks and housing. People in their 50's strongly disliked the idea of residential care.[22]
- Social exclusion and Older People towards a conceptual framework suggests that the creation of deprived areas and neighbourhoods hits older people harder than other groups, in part because they are more likely to rely on a cash economy (loss of banks and post offices makes accessing fund hard), food and basic goods cost more, general sense of loss when shops and workplaces close. Feeling of isolation, loss and a retreat by communities may be felt even greater by ethnic minority groups who start off from an isolated position.[23]
- Whilst over 60% of people aged under 60 see themselves as staying in their own home when they reach old age over a quarter would see themselves living in some form of sheltered or special accommodation. Only 11% would move to a private care home and 7% a local authority care home.[24]
- Older Home Owners define the advantages and disadvantage of home ownership under three main themes:

    - It offers independence although it also burdens people with responsibilities for repairs and maintenance.
    - It is seen as a capital asset or investment although there is concern again about the cost of repairs, that it means some forms of financial help are not available to them and that they may need to sell their home to pay for care.

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[20] Is enhanced sheltered housing an effective replacement for residential care for older people? Dec 2000 JRF

[21] Inequalities in Quality of Life Among People aged 75 years and over in Great Britain. Breeze, Grundy, Fletcher, Wilkinson, Jones and Bulpitt, March 2002.

[22] Looking Forward to Care In Old Age Levenson, Jeyasingham and Joule, Kings Fund 2005

[23] Social exclusion and Older People towards a conceptual framework: Scharf, Phillipson, Kinston and Smith, Centre for Social gerontology Working Paper, 2000

[24] MORI for CSCI 2005

- Older people who are home owners see their home ownership as an achievement however they can also see themselves as tied down by the property[25].

Surveys of anticipated future need

Local studies

During 2005 a local, multi-agency strategy, '*Never Too Old'*[26], was produced. Its development was based on a 'bottom-up approach' and is effectively a strategy for older people by older people. As a consequence the views of older residents in York were widely canvassed. Their particular priority areas were identified as being:

- Power and control;
- Maintaining independence;
- Staying healthy;
- Planning for future needs.

Specific areas of concerns within these priority areas were identified but there was no further prioritisation within this list:

- Wider partnership working utilising all partners including voluntary and independent sector;
- Assessments done at the speed and convenience of the older person concerned;
- Services being available promptly;
- Avoidance of assumptions about the needs and abilities of the person concerned;
- Avoidance of age discriminatory practice;
- Delivery of an equitable service for both older people and their carers;
- Transparent service provision with an honest assessment of what can be done and what is available;
- Improved communication between those receiving and providing services;
- Timely provision of information to those identified as needing it;
- Informed individuals;

[25] Older owner occupiers perceptions of home ownership JRF Sept 1999

[26] Too Old Older People's Strategy, Selby, York & Easingwold Older People's Partnership, 2005.

- Greater awareness of public health issues and initiatives;
- Proactive and timely service provision with reduced frequency of crises;
- Health of carers maintained and improved and consequently maintaining the support and independence of the 'cared for'.
- Increased emphasis on preventative services;
- Equitable service provision (health, social care, leisure, education & transport);
- Improved communication between those providing services and their elderly recipients;
- Quality of life issues addressed;
- Emphasis of service provision around rehabilitation and enablement;
- Measuring outcomes rather than service volume;
- Genuine consultation with older people.

Another specific piece of consultation with older people took place in the Acomb ward during 2001 as part of a Health Needs Assessment exercise[27]. This work highlighted specific outputs to respond to older people's concerns about being socially isolated. The recommendations that came out of this particular piece of consultation were as follows:

- A Drop In Centre established for the area.
- Improved Toilet Facilities in the area
- Encourage existing coffee shops to offer special rates for seniors and the opportunity to 'sit and linger' at certain times of day.
- Groups/organisations to publicise and promote the service offered.
- Undertake a survey of existing transport available to older people, both public and private, and raise awareness with appropriate publicity.
- Offer information on local services, activities and support available to older people living in York. (ii) Evaluate the 'user friendliness' of 'Out & About' Booklet, (initiated in Acomb as a result of the HNA).

3. Service user and carer profiling

There is not a vast amount of data about service users and carers in York that has been quantified and analysed. However, there are a number of national studies that highlight problems at the care and health interface For example:

[27] Executive Summary of the Survey of Services and Activities for People aged 50+ in Acomb, Age Concern York, 2001

- A study in one local authority estimated that 30% of older people admitted to A&E Departments came in with a dehydrated related illness. Over half of those had come from a care home.[28]
- An American study of continence showed that incontinence increases the likelihood of an older person being admitted to a care home.[29] Despite 80% of services having a written policy that pads should be available on the basis of clinical need, 81% of primary care and 76% of care home services limit the maximum number of daily pads for individuals. 60% of primary and 70% of secondary care patients with bladder or bowel problems receive pads as a way of managing their condition, rather than treating the underlying problem[30].

The following table shows the number of people aged 65 and over, in York, who received services from social services because of substantial or critical care needs during 2005/6 together with their primary customer group (as detailed in the pf1 return). Note: Some customers may have received both community and residential services, or residential and nursing services during the year

[28] Just add water, Graham Hopkins, Community Care, 13th October 2005

[29] Medically recognised urinary incontinence and risks of hospitalisation, nursing home admission and mortality. Thom, Haan, VanDen Eden, Age and Ageing 1997, Vol 26

[30] Report of National Audit of Continence Care, Royal College of Physicians, November 2005

Table 11: Total number of clients in York aged 65 and over, receiving services during 2005-2006, by primary client type, and service type

Primary client type	Total customers	Community based services	LA residential	Independent residential	Nursing
Physical Disability	4698	4170	230	187	333
Unknown	268	233	9	17	19
Phys dis	2804	2559	85	99	181
Frailty/temp illness	1329	1114	115	61	120
Hearing impaired	95	86	5	2	4
Visual impaired	161	143	12	6	5
Dual sensory loss	41	35	4	2	4
Mental Health	453	265	49	92	104
Dementia	287	162	28	48	87
Vulnerable people	32	28	5	2	1
Learning disability	36	23	5	11	2
Substance misuse	4	3	1	0	0
No record	0	0	0	0	0
TOTAL OF ABOVE	**5223**	**4489**	**290**	**292**	**440**

Selby and York PCT have developed multi-professionals teams (MPT) to provide a proactive and targeted approach to the management of individuals with ongoing health needs. An analysis of the first ten months of service provision was completed in January 2006. This highlights that the majority of patients, 88% (149), were aged 65 and over. It also indicated that 54% (91) were also known to Social Services. It has also confirmed that the vast majority of people with long-term conditions will have more than one medical condition to cope with. The ten month analysis highlighted that 86% had two or more medical conditions, with the most prevalent being:

- COPD (30%)
- Hypertension (25%)
- Osteoarthritis (16%)
- Heart Failure (16%)
- Ischaemic Heart Disease (15%)
- Diabetes (13%)

Work is currently in progress led by North Yorkshire and York PCT, to look in more detail at the needs in relation to falls, strokes, heart failure and COPD, and the impact of these conditions on the demand for unplanned hospital admissions.

Although not a detailed review of service users needs information can also be drawn from the Performance Assessment Framework:

- Our performance on reducing the number of older people admitted on a permanent basis to residential or nursing care is very good (C72)
- Our delivery of equipment and adaptations within targets is very good (D54)
- Our contribution to supporting older people to live at home is good (C32)
- Our ability (with the PCT) to minimise delayed transfer of care is average (D41)
- Our provision of intensive home care to over 65's is acceptable, but possible room for improvement (C28)
- Our support to enabling adults and older people to gain "control" over their provision of care services by providing direct payment is acceptable (with room for improvement (C51)
- Waiting times for assessments is acceptable (with room for improvement) (D55)

Carers

The Audit Commission (2004) found that carers who provide over 50 hours care per week are twice as likely to suffer from poor health as other people. Carers who do not get a break are twice as likely to suffer from mental health problems as those who do. The health of carers is also more likely to deteriorate over time compared with non-carers.

People in their 50's felt that their children would be unlikely to be their main or sole carers although discussing their future care needs with their children would be very difficult.[31]

The general household survey in 1995[32], although ten years old provides a good analysis of national data regarding carers:

i) Prevalence of informal care

- One adult in eight (13%) was providing informal care and one in 6 households (17%) contained a carer.
- Four per cent of adults cared for someone living with them and 8% looked after people living elsewhere. The survey findings indicate that there are about 5.7 million carers overall in Great Britain with about 1.9 million caring for someone in the same household.
- Four per cent of adults in Great Britain (representing about 1.7 million) devoted at least twenty hours per week to caring and 8% (about 3.7 million) carried the main responsibility for looking after someone (that is, they spent more time than anyone else on the dependant).
- Women were more likely to be carers than men but the difference was not very marked, 14% compared with 11%. However, since there are more women than men in the total adult population of Great Britain, it is true that the number of women caring is considerably greater than that of men, 3.3 million compared with 2.4 million.
- The small difference between the proportions of women and men caring was attributable to the higher proportion of women looking after someone outside the household (10% of women and 7% of men). Women were also more likely to carry the main responsibility for caring (9% of women and 6% of men).
- Five per cent of adults looked after parents and 3% cared for friends and neighbours.
- The peak age for caring was 45-64. One fifth of adults in this age group were providing informal care.

[31] Looking Forward to Care In Old Age Levenson, Jeyasingham and Joule, Kings Fund 2005

[32] General Household Survey 1995

- Among men of working age, one in six of the economically inactive were carers compared with one in ten of those in work or unemployed. Among non-married women the proportion caring varied little according to economic status, but among married women, the economically inactive were the group most likely to be caring followed by those working part time.

ii) Who is caring for whom?

In total, 18% of carers were looking after more than one dependant. Nine out of ten carers were looking after someone who was related to them; four out of ten were caring for parents or parents-in-law and two out of ten were looking after a spouse.

Where carers were looking after someone in their own household, just over a half were caring for a spouse; just over a fifth were caring for parents or parents-in-law and a similar proportion were caring for children.

Of carers with dependants in other households, just over a half were looking after parents or parents-in-law; a fifth were caring for relations other than parents or children and just over a fifth were looking after friends or neighbours.

Sixty per cent of carers had dependants with physical disabilities only; a further 15% had dependants with mental and physical disabilities and seven per cent had dependants with mental disabilities only. Almost all remaining carers said that their dependant's disability was the result of ageing.

iii) The nature of care

- A total of 24% of carers had been looking after their dependant for at least 10 years and a further 23% had been caring for between five and nine years. Just under a third of carers who lived with their dependants had been caring for them for at least 10 years.
- Among carers with a dependant in their own household, just under 60% helped with personal care; a similar proportion provided physical help; just under 70% provided practical help and nearly 80% generally kept an eye on them. Carers with dependants in households other than in their own were much less likely to provide personal care.

iv) Time spent on caring activities

- There was a slight preponderance of men among the group of carers spending the least amount of time caring, but apart from this the amounts of time spent by men and women on caring were very similar.
- Over a third of carers with a dependant in another household spent fewer than five hours a week caring while nearly two thirds of those who lived in the same household as their dependant spent at least 20 hours a week caring.

- Of carers devoting at least 20 hours week to caring: over 60% were women; three quarters were aged 45 or over and seven out of ten shared their home with their dependant. Nine out of ten were main carers; nine out of ten were looking after a close relative and a third were caring for dependants with mental disability.

v) Who supports the carers?

- Over a third of all carers reported that no-one else helped them look after their dependants. A further 26% did receive help but spent more time looking after their dependant than anyone else and just under 10% shared the task of caring with another. Women were more likely than men to be caring unaided while men were more likely to be `non-main carers'.
- In total, 59% of all carers had main dependants who did not receive regular visits from health, social or voluntary services.
- Dependants who lived with their carers were much less likely to receive regular visits from service providers than those who lived in another household.

In York the wards of Haxby and Wigginton, Huntington and New Earswick, Heworth, Westfield, Dringhouses and Woodthorpe and Hull Road have the highest numbers of older carers.

Table 12: Provision of 50 hours or more care per week by older people

All people	People aged 75-84	People aged 85+
1,157	448	87

Source: NOMIS (Census Table SO25)

In the year ending March 2006 1,475 carers were identified during care assessments. We do not have details on how many of these were older people. 607 carers were identified as carrying out substantial and regular care. Carers are likely to be vulnerable to health problems of their own, particularly stress related and lifting injuries, and the higher the level of care they provide, the more vulnerable they are likely to be. Table 12 shows the numbers identified from the census who were providing over 50 hours care a week

4. Analysis of met, but unsatisfied demand

Understanding the above is a crucial part of the analysis that needs to be undertaken in developing a commissioning strategy. However, this is not an easy process in York because the information sources required to answer these questions

are limited, and it requires a number of discussions with partners in order to understand the relationships between, and effects upon, a whole range of services. For example; low levels of health service physiotherapy provision may impact on a person's capacity to recover from a stroke which may in turn lead to diminished mobility which may eventually require considerably increased social care provision. Equally, the absence of an early social care intervention may have a consequence for health services that requires hospital admission.

Effective joint commissioning requires a strong evidence base and the capacity to track back through systems to establish cause and effect across organisational boundaries. The commissioning strategy needs to identify, with health and housing, key initial questions and topics to be addressed.

Summary of Current Demand Data

Although there are still gaps in the information we have about needs, primarily around the specific health needs and profiles for the city, we can identify a number of key factors that need to be taken into account in planning service provision:

- We can expect the population of people over 65 in York to grow by 31% over the next 15 years, an additional 9,540 people. Within that growth there will be more men than women although longevity in men is increasing disproportionately. Single women may feel more anxious about living alone in the family home and may feel more vulnerable. Single older women are more likely to suffer social exclusion than their male counterparts.
- Mental health and physical and sensory disability needs will increase as the population grows and ages. Dementia will affect around 700 additional older people within the next 15 years. Given that dementia is likely to consume high level resources the natural growth in this population is concerning. Currently social care provides few services for other mental health conditions in older people.
- Current prevalence figures for clinical depression can be used to project an estimated additional 800 to 1,400 additional older people with clinical depression
- If our current service provision continues at the same level these increases in population and associated needs will mean an additional 163 people could require services because of mental health needs, 105 because of dementia.
- Physical and sensory disabilities can be expected to affect an additional 6,000 people by 2020. If the local authority continues to provide services at the same level reflected in Table 11, this would mean an additional 2,322 service users, with 278 of these potentially needing the equivalent of residential or nursing

home care, and over 2,000 additional older people needing support in the community

- Stroke deaths for older people rose above the national average between 2001-2003 and the prevalence of diabetes is increasing. We predict that approximately 5,700 will be diagnosed with diabetes in 2010, although it is difficult to gauge the exact impact on health and social care needs.
- We can expect an increase of approximately 1,500 older people who will have one fall, and an additional 375 who will experience one or more fall in 2020. While all falls may not cause serious injury they can impact on an older persons feeling of confidence and social isolation caused by restricted mobility.
- There are some areas of the city with much higher numbers of older people than others. Three of the six higher density areas are in the outlying wards and villages: Haxby and Wigginton, Huntington and New Earswick and rural West York. Three are on the outskirts of the city centre: Westfield, Heworth and Dringhouses and Woodthorpe. Linked to these population levels all of these wards also have higher numbers of older people living alone, the number suffering from dementia and the number of older carers, all of which can lead to vulnerability and a need for services.
- We would expect a higher need for publicly funded services to come from those wards where there are a number of factors which would indicate social exclusion or deprivation, such as long term limiting illness, no access to a car, no central heating and living alone. Westfield, Heworth, and Micklegate are the wards that have the highest number of pensioners experiencing some or all of these issues.
- We are able to assume that as there are a significant number of older people who are 'asset rich' due to their home ownership, will potentially have the equity to fund care needs, or to purchase specialist housing.
- Whilst there is no one significant community of BME older people within York we would expect numbers to increase in line with general population increases therefore, we would need to ensure that future services provide flexibility and responsiveness to a variety of needs.

Further Demand Data to be identified and the contribution this will make to the commissioning strategy

One conclusion this needs analysis is an improved understanding of what we know about our population and what we don't know. This has been highlighted by the difficulty in several instances to access the information needed to effectively commission services and understand wider needs. Therefore, we have ended this section by identifying what further work needs to be undertaken to develop our thinking on what and where these information sources need to be. Our current view is that we would like to pursue the following:

- Further thinking needs to be given to how population/patient/service user/ tenant information is captured and analysed across the authority. It is often difficult to compare data about conditions, eg, stroke, cancer, continence, etc with data about outcomes from those conditions, ie aspects of mobility and functionality, with services received, eg, home care day centres. A base line might at least be a shared information depository of data that all three agencies collect at least quarterly.
- Diabetes, stokes and falls are all conditions that could be reduced through good prevention services and where they still occur, the impact of those conditions on peoples lives could be diminished. At present there is not enough information about the relationship between these conditions and their prevalence amongst current service users and the impact this may have on future service provision.
- There is a need to share our knowledge of the health and social care needs of older people within, and external to, the local authority in order to influence developments in infrastructure so that communities support the aspiration, through that infrastructure, for a higher proportion of older people to remain within the community. That may be through planning regulations and controls, through the maintenance of local shops and support services and through design such as in buildings, drop kerbs and other aspects of the urban environment.
- What is known about the relationship between current demand and service provision, eg, which services are under pressure (occupational therapy, day care), is this real or illusory, where is there over supply?
- Is the intensity of services provided sufficient to achieve the outcomes desired, eg, in stroke services do we know what intensity of rehabilitation is required for a particular individual to achieve maximum potential recovery?
- Are there needs being presented where targeted interventions could prevent worse outcomes but where this is not occurring, eg, people coming into care homes where the provision of an alternative, community based service could prevent this happening?
- Are there unintended consequences to current service provision, eg, is the provision of mobility aids actually acerbating immobility?
- Is the point at which intervention occurs the point at which it is most likely to deliver the best outcomes; eg, are eligibility criteria effective rationing devices or do they debar people form provision at a time when it may have the greatest preventative impact?
- In terms of service users and carers there are a number of unanswered issues about provision:

- How can we identify earlier and understand incidence of diabetes, COPD and depression in our clients in order to improve our response and monitoring of outcomes?
- Why do older people and especially those with dementia enter hospital and/or long term care and what does this tell us in order to design better prevention services?
- How many people with dementia access our current services – who are they (age, gender, ethnicity, accommodation status) and what do they access?
- How many people care for people with dementia – who are they and how much care do they give and how would increased services for carers improve the overall contribution to improving support for older people in the community?
- What happens when services are not delivered or are delayed, eg, aids and adaptations?
- What people expect when they ask for a service and whether this is met?
- What might happen if service supply is restricted?

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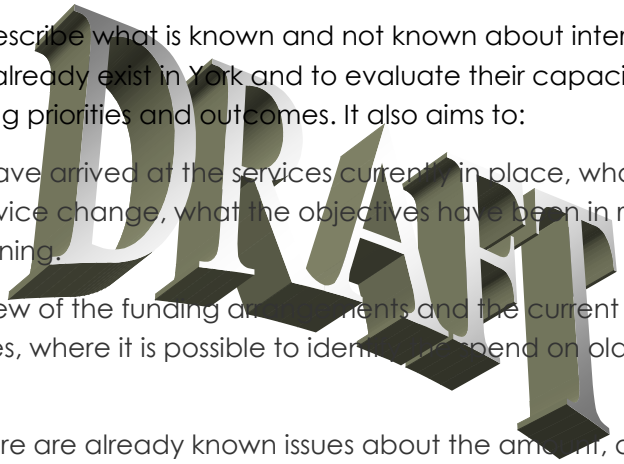
Annex 2

DRAFT SERVICES REVIEW



This chapter aims to describe what is known and not known about internal and external services that already exist in York and to evaluate their capacity to meet strategic commissioning priorities and outcomes. It also aims to:

- Explain how we have arrived at the services currently in place, what the drivers have been for service change, what the objectives have been in recent service commissioning.
- Provide an overview of the funding arrangements and the current levels of funding for services, where it is possible to identify spend on older peoples' services.
- Identify where there are already known issues about the amount, quality, cost or sustainability of any service over the next 15 years, and consider key pressures that will affect all providers over that timescale.

How we have arrived at the current configuration of services

The Best Value Review of 24 hour Care for Older People was completed in 2001, and has been one of the key drivers for service change over the last five years. It built on a report from the Nuffield Institute[1], and included extensive consultation with older people and providers, as well as a review of best practice. It recommended that additional capacity be developed in Extra Care housing, home care, day care and care management time, and that specialist residential care for older people with mental health needs, and rehabilitation needs be developed within the local authorities own establishments. However, the review was not conducted jointly with health and a more integrated review might have realised even more benefits.

The review aimed to deliver services that would support more older people to live independently for longer in their own homes, and meet an anticipated increase in demand for services because of the growing older population (expected to be 10% between 2000 and 2005). There was an expectation that demand for residential care would reduce, and that needs of older people supported by the local authority in a care home setting would increase and become more complex.

The implementation of the action plan following the review has delivered a wider choice of services for older people and helped to reduce the number of older people needing a care home placement. The number of admissions to care for

[1] Making Connections – a review of options for 24 hour care for older people in York ,Nuffield Institute, 2000

supported residents has decreased from 113 in 2001/2 to 75 in 2005/6. The service changes have also supported the reduction in numbers of people waiting in hospital for suitable discharge arrangements. In 2001/2 delayed discharges were regularly at 50 plus. Last year they were in single figures and often at zero.

Other changes that have helped achieve this turn round have been the strengthening of the care management arrangements and the introduction of services which allow key decisions about any move to residential care to be taken outside of a hospital setting.

Overall the outputs from the review were:

- The development of a specialist residential home for older people with dementia,
- Investment in two sheltered housing schemes to provide an additional two extra care schemes, complementing the two residential homes already converted to provide extra care, within the local authority stock,
- The decommissioning of a sheltered housing scheme with shared bathrooms, and the re-development of the building as an Intermediate Care facility
- Additional 10% investment in home care services and
- 10% increased capacity in care management teams.

The locations for new services were chosen carefully, so that:

- Geographical distribution was well balanced
- Services were in locations which offered good access to local shops and transport links and where there were significant populations of older people
- Existing suitable establishments could be appropriately and cost effectively adapted.

The four Extra Care schemes are based in Westfield, Heworth, Micklegate and Clifton wards. We do not have properties in some of the wards where there are high numbers of older people, (Huntington and New Earswick, Haxby and Wiggington) but we are in discussions with our RSL partners to explore the possibility of developing properties in New Earswick and Huntington.

Because of capacity issues and other pressing priorities we have not addressed the issues raised through the Best Value Review about day care services. Thus we have

not added any significant investment or remodelled services to deliver the 10% increase in capacity that was considered necessary. This means that we are probably not making best use of the resources we do have, and not offering the quality of care that we would wish to.

In addition to the Best Value review, other drivers for change have been:

- The need to jointly realign services with Health in response to delayed discharges in the acute hospital, and
- The need to realise savings because of financial pressures.
- A local initiative by Joseph Rowntree Trust over 6 years ago, started discussions between the Council, the PCT and two voluntary organisations involved in the care of older people with mental health needs.

The objective of this last initiative was to agree on the options for improved services for older people with mental health and led to the joint commissioning of a report by Dementia North in 2002[2]. From this a shared vision was agreed in 2003/4 and dialogue continues on ways to achieve the aim of changing current investment across the statutory agencies, to provide a greater community focus.

Other services have not been the subject of in depth review. Service patterns and models of delivery are on the whole historic, and any changes have been prompted by the need for efficiency savings. It is not always clear that services meet the needs of those in highest need therefore, what outcomes they are trying to deliver, or whether they are the best delivery models to achieve the required outcomes.

Preventive services in particular have grown incrementally. They have often been developed as the result of the knowledge and initiative of the voluntary sector seeking funding for new ideas. The resulting services have been popular and well thought of, but are often vulnerable to funding changes. As a result Voluntary Organisations spend a lot of time chasing funding.

Funding arrangements

Both health and social care agencies are likely to be subject to significant financial pressures over the coming years. For the last two years social services budgets for community support have overspent. The Authority has a low tax base, and one of

[2] Review of Services for Older people with Mental Health Problems in York; Dementia North 2002

the lowest grant settlements from the government. This financial pressure is not expected to change significantly over the next 15 years, unless local government financing is changed significantly.

The PCT has just completed a Financial Recovery Plan, as a result of a £23m deficit last year. Budget reductions are planned across the whole organisation, with a reduction in capacity in intermediate care planned, and a review under way to reduce costs for unplanned care for older people.

Although these financial pressures bring big challenges, there is also an opportunity for better joint commissioning, as both organisations have to look more closely at which services are effective and which need to be changed. It is expected that the new York and North Yorkshire PCT will soon start discussions on a joint commissioning framework with both local authorities covered by the new organisation.

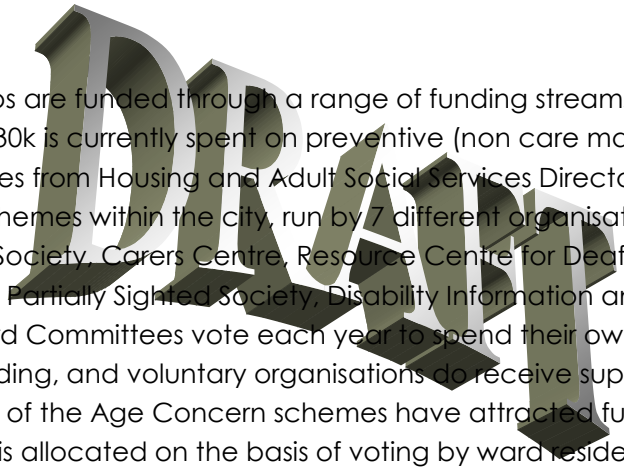
At present there are no pooled budgets in York for older people. Within social services the budgets are allocated at locality level to teams who provide services to both older people and people with disability or health conditions. Community Health services budgets are not allocated according to age, save for the PCTs mental health services for older people which operates as a separate management unit.

It is recognised that there could be benefits in pooling budgets, particularly in relation to older people with mental health needs. The Dementia North report made it clear that our current service configurations could be changed to provide more integrated community based services. However financial issues for both organisations, and capacity issues, have delayed any real progress on this.

In 2005/6 City of York Council spent around £21m on older peoples services, including assessment and care management.

- £6m was spent providing care at home with £2.48m spent in the private sector.
- £9.5m was the net expenditure on residential and nursing home care with £5.3m spent in the independent sector
- £1m on day care and
- £550K on equipment and adaptations (PSS Expenditure 2005-06).

In general unit costs for in house services are higher than for independent sector services. This is partly because of the recharges assigned to in house services for all corporate functions within the council; there are issues about 'non –contact time' and costs associated with sickness cover as well.



Voluntary sector groups are funded through a range of funding streams, of which the Council is one. £230k is currently spent on preventive (non care managed) voluntary sector services from Housing and Adult Social Services Directorate. This funding supports 21 schemes within the city, run by 7 different organisations (Age Concern, Alzheimer's Society, Carers Centre, Resource Centre for Deafened People, York Blind and Partially Sighted Society, Disability Information and Advice Centre and APS). Ward Committees vote each year to spend their own allocation of neighbourhood funding, and voluntary organisations do receive support through this, for example some of the Age Concern schemes have attracted funding in some wards. Funding is allocated on the basis of voting by ward residents. Some funding has previously been available through Safer York Partnership.

Discussions were held with the voluntary sector in 2005, to explore the possibility of them increasing their services, should changes to social care eligibility criteria be necessary, to achieve a balanced budget. The voluntary sector has already delivered a wider choice of services for older people and helped to reduce the number of older people needing residential care. It has also supported the reduction in numbers of people waiting in hospital for suitable discharge arrangements.

The Supporting People Programme spent £895k on older people's schemes in 2005-6, providing support to around 5000 older people through the community alarm schemes, and nearly 1700 in supported accommodation. In 2005, unit costs, on average, were within the regional benchmarked third quartile. There are no current plans for additional investment in this part of the programme, although older people with mental health needs is a priority customer group for investment, if efficiencies can be found from other services. It is planned that all Supporting People services will be subject to market testing within the next three to six years.

There is a risk that the Supporting People Grant from DCLG will reduce in real terms over the next nine years, if the historic allocation of money is replaced by a distribution formula. Efficiencies will need to be found in all customer groups if this is the case.

Analysis of current services; challenges and opportunities

Our analysis of our current services has focused in the main on:

- Quantitative analysis– the location of services in York, price, levels of demand, and relevance to future types of service provision required.
- Qualitative analysis – evaluating the quality of the service based on outcomes

Whilst required to complete a comprehensive analysis of services, the following areas are to be addressed as part of our on-going development of our commissioning strategy.

- Mapping best practice for the future – looking at models of good practice built on research and best practice examples with a rationale as to how this provision would be better than that currently available.
- A cost benefit analysis of current provision - to determine whether services offer value for money or whether alternative forms of provision or re-configurations might offer both a better service at a lower price.

We have looked at the services within four main categories:

- Prevention,
- Housing,
- Help at Home (which includes domiciliary care, equipment and day care) and
- Residential and Nursing Care.

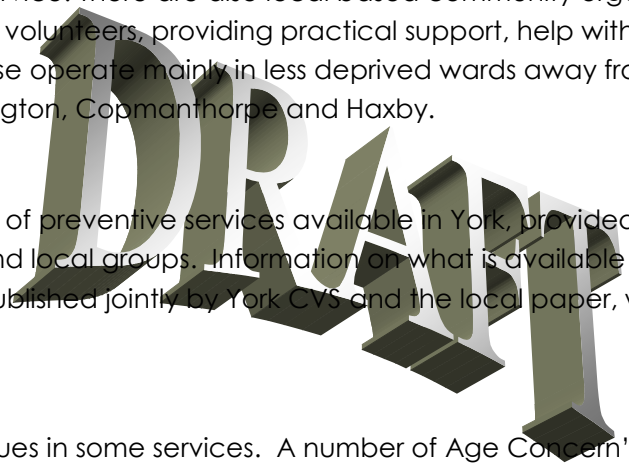
Any future changes to services will impact on services in other categories, but for this section within the Commissioning Strategy we will not attempt to map all of the links and dependencies between services. Outline details of the services currently available are provided in Annex 1, which contains a service map.

Preventive services

We do not have a Prevention strategy and this is reflected in the way services have grown up incrementally, and in a rather ad hoc way.

Funding is a concern for the voluntary sector, which provides most of the preventive services. Although there is a Voluntary Sector Compact, to which the Local Authority and the PCT are signed up, there is some tension over funding reductions this year from the PCT and the Council, as well as the Safer York Partnership. The reductions have been partly because of financial pressures for the funding organisations, but other issues have been raised about how funders know whether services are effective as well as popular

Most funded services are available across the city, but there are some services that are funded by ward committees that have a more local focus. For example Age Concern receives support from some, but not all ward committees for their community support service. There are also local based community organisations, who rely on very local volunteers, providing practical support, help with shopping or transport help. These operate mainly in less deprived wards away from the city centre, such as Huntington, Copmanthorpe and Haxby.



There is a good range of preventive services available in York, provided by a number of national and local groups. Information on what is available is provided through two guides published jointly by York CVS and the local paper, with support from the Council.

There are capacity issues in some services. A number of Age Concern's services, such as the befriending and sitting services, have waiting lists for example.

Practical support is identified by older people in York, and in Government strategies, as important in helping older people remain in their own homes. Practical support is available from Age Concern's Handyperson scheme, from some community voluntary groups, and through the Housing Department for Council tenants. Funding for the Age Concern scheme is uncertain and some services do not operate across the whole of the city.

Opportunities for active involvement within the community are important to ensure the well being and inclusion of the older population. Isolation and exclusion can contribute to depression, which we have already identified can lead to increased need for health care and residential care services. Social activities are offered through a wide range of interest groups, faith groups and voluntary organisations. The Older People's Assembly supports an annual Over 50's festival which aims to encourage greater awareness and involvement in community activities. Older people can also access leisure, sport and learning opportunities with some classes and activities targeting older people. For those with mobility and health needs there are some specific services, with Age Concern, the Deaf Resource centre and the Carers centre all offering activities and outings.

Financial advice and support is available, and effective in increasing income from benefit take-up. It is estimated that an additional £4.3m benefits was claimed as a result of the work of the CAB, Age Concern, DIAC (Disability Information and Advice Centre) and the Council Welfare Benefits Team in 2004/5. There are financial advisers within the private sector to offer advice on pensions, investments, equity release, but we have a limited understanding of this market at present. The new home care services will include a new Home Support Team, funded jointly by

social care and Supporting People, which will be able to help older people with day to day finances, including collection of pensions. We provide a limited amount of support to older people in receipt of services, who are in need of Court of Protection

Advice, information and advocacy are all available from a range of organisations, some specialist, such as the Alzheimer's Society, York Blind and Partially Sighted Society and the Deaf Resource Centre and some more general such as CAB, Age Concern and Older Citizens Advocacy York (OCAY)

We know that regular physical activity improves health and well-being. The PCT has some good initiatives; In Selby & York PCT's 2005 Annual Public Health Report specific activities that promote improved strength, coordination and balance beneficial to older people were highlighted. Consequently local actions were identified to:

- Further develop and support chair based exercise programmes;
- Further develop and support postural stability classes across the PCT locality, targeting older people who may be at risk of falling;
- Maintain the successful Health Walks programme, which undertake up to 240 such walks each year.

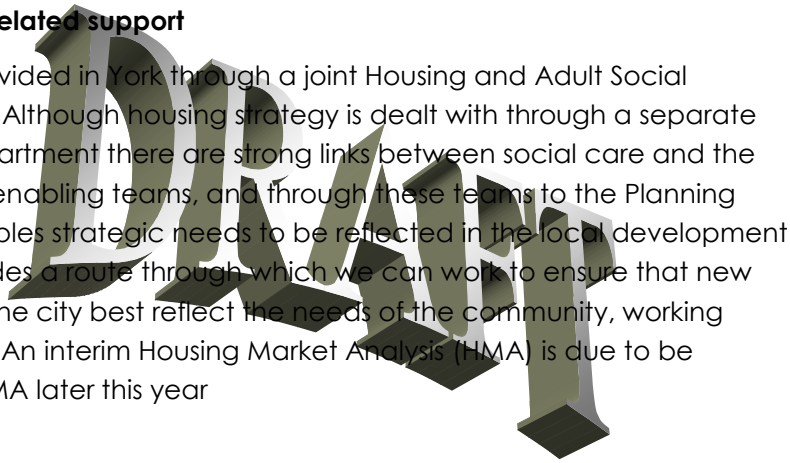
In our discussions with older people, we have been considering how we might encourage older people, and care workers to train as trainers to support these initiatives.

Podiatry services can alleviate conditions that affect mobility, isolation and risk of falls. Services are provided through the PCT for the whole of the Selby and York PCT locality and as such information specific York is difficult to disaggregate. The aim of these services is to reduce pain and achieve maximum improvement in foot and lower limb conditions, thus improving or maintaining the patient's mobility. Access to the service is via GPs, hospital consultants or district nurses.

50% of new referrals tend to be for people over the age of 65. The vast majority of this work is for chronic conditions which requires ongoing treatment. As these people get older their foot conditions get worse, which therefore result in the need for more capacity for appointments each year. This is reflected in activity figures for 2005, which indicated that 51% (1,400) of all new referrals were for people aged 65 and over and almost 80% (43,000) of subsequent contacts. All this is provided by a

workforce of 30WTEs, providing a capacity of 215 new patients each month against a referral rate of 250.

Housing and housing related support



Social services are provided in York through a joint Housing and Adult Social Services Department. Although housing strategy is dealt with through a separate division within the department there are strong links between social care and the housing strategy and enabling teams, and through these teams to the Planning Department. This enables strategic needs to be reflected in the local development framework, and provides a route through which we can work to ensure that new developments within the city best reflect the needs of the community, working within this framework. An interim Housing Market Analysis (HMA) is due to be replaced with a full HMA later this year

Older people want to live independently for as long as possible. This, for many, means staying where they have lived for many years. To support this we need to ensure that we can offer advice and support with regard to property adaptation and repair and maintenance. However, some older people will want to move to specialist accommodation. This may be for improved security, company, on site support or lower maintenance requirements. 40% of older adults now find themselves needing or wanting to move home at least once past the age of 65 years (including into residential and nursing care)[3] and a quarter of adults over the age of 60 indicated that some form of specialist housing would be their preferred future option of housing[4].

Our Adaptation service is located within the Housing Strategy and Enabling team, with good links to the Occupational Therapists and with the new Home Improvement Agency. The team works alongside the service for private landlord property improvements. The service manages demand within budget at present but with more property owners we should expect the demand for help with property adaptations to increase. Funding for the service, however, is likely to reduce as financial pressures continue to affect the Council.

The Home Improvement Agency in York is only two years old. The contract was awarded, by tender, to a local housing association. There are some issues about security of some of the funding, but it will be important to ensure sustainability of a service if we are to be able to help older people find ways to repair and maintain

[3] Bebbington, Darton, Netten, *Care Homes for Older People; Volume Two, admissions needs and outcomes.* 1995

[4] MORI : The Aspirations of Older People, 2004

their property. The service currently has good links with the Age Concern Handyperson scheme, and this is a link we would wish to preserve.

The balance of provision for sheltered housing is mainly within the social rented sector, with 33 schemes and 1700 tenancies receiving Supporting People subsidies. Within the whole social rented sector there is at least one scheme in each of the wards in the city, with the exception of Wheldrake, which has the second lowest number of people over 65 (380) according to the 2001 census. 17 schemes are managed by the Council, with a high proportion of those in city centre wards. 10 of these schemes have on site support during office hours. Five are dispersed property schemes. All have access to the Community Alarm scheme out of office hours.

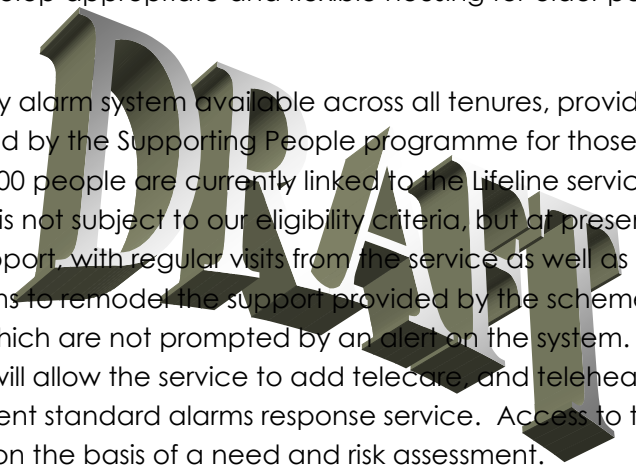
With the changes in tenure expected over the next 10 years, there may be over capacity within the rented sector. There are already some schemes which experience delays in filling tenancies, and the Council has recently decommissioned one of the hard –wired schemes, which was proving difficult to let. The scheme did not have an on site warden and had higher support charges than the Community Alarm scheme.

There are six extra care or very sheltered housing schemes within the city, and one retirement village with residential and nursing care available within the village. Four of the Extra Care schemes are Council owned. We have continued discussions with two RSL's to explore the possibility of adapting other sheltered housing schemes to provide additional extra care choices, to the north of the city in Huntington and New Earswick, where there are large numbers of older people, with over 20% living in social rented sector properties, but where the local authority holds no housing stock.

The Council is just embarking on a project to demolish 100 bungalows which would not easily meet Decent Homes standards. There is a commitment to ensure that these 100 homes are reprovided in the redevelopment plans, with new accommodation for older people incorporating innovative design, and best use of any new technology to help support people at home for longer. The Council is seeking to work in partnership to reprovide these homes.

There is a much smaller choice at present within the private 'to buy' sector. We hold and provide limited information about those schemes that do exist. We know of 9 schemes in York.

An interim Housing Market Assessment undertaken this year shows that York already is a net importer of pensioner households in respect of house moves. There are two major planning enquiries underway at present, the outcome of either could offer an opportunity to develop appropriate and flexible housing for older people.



We have a community alarm system available across all tenures, provided by the Council, and subsidised by the Supporting People programme for those on benefits and low incomes. 2,500 people are currently linked to the Lifeline service. Access to the lifeline scheme is not subject to our eligibility criteria, but at present it offers only one model of support, with regular visits from the service as well as response to alarms. There are plans to remodel the support provided by the scheme to reduce the monitoring visits which are not prompted by an alert on the system. The increase in capacity will allow the service to add telecare, and telehealth monitoring to the current standard alarms response service. Access to telecare services is likely to be on the basis of a need and risk assessment.

Help at home

Domiciliary care

We would expect that when the remodelling of home care services is complete we should have a service that is fit for the medium term future. All new referrals will be to the Rapid Response team, who will aim to increase the customers' independence and reduce the level of care needed beyond six weeks. Those who do still need help with personal care will be referred on to either a locality based team, (external provider) or if the needs are more complex to one of a number of specialist teams (in house provider), or if they need no personal care but do need support with daily living, to a Home Support Team. It is expected that the new service models and new contracts will offer savings to bring the budgets back in balance, after two years of overspending, and increase capacity to meet growing demand.

We have seen over the last two years that the introduction of a rapid response team has reduced the longer term care packages to a significant proportion of cases. Since the team was introduced around 62% of referrals from hospital and 45% of those from the community based Intake team have resulted in reduced or no care packages after 6 weeks. This finding had a significant influence on the development of the new home care service model

Although we can meet most of the assessed demand for home care through the current providers, there are issues about value for money from the in house services. Within the new commissioning arrangements there is a requirement that the amount of non – contact time funded within the in house services will reduce.

This will release capacity to meet growing demand, and at the same time bring the budgets back within planned expenditure.

The introduction of three locality based contracts will reduce the number of care providers that the Council places business with, but it will hopefully help to address recruitment and retention issues as the agencies will have guaranteed business.

CSCI's Local Authority Market Analyser indicates that domiciliary care agencies in York in general meet a higher percentage of the standards than the England average. Areas where there are lower than average scores are safe working practices, risk assessments and business premises.

Intermediate care and transitional care

We believe there is evidence that Intermediate Care services and the introduction of Transitional Care beds (which allow time to assess more fully whether someone could return home, or need residential care after a hospital admission) have contributed to the reduction in delayed discharges, referred to at the beginning of this chapter. An evaluation of the impact of the conversion of a decommissioned sheltered housing scheme to provide 29 intermediate care beds at Archways in 2004 had to be shelved because of cost and capacity issues. The PCT Financial Recovery Plan identifies a planned reduction of funding for the residential beds, from 40 to 24, and it is not clear what impact this will have on the whole system.

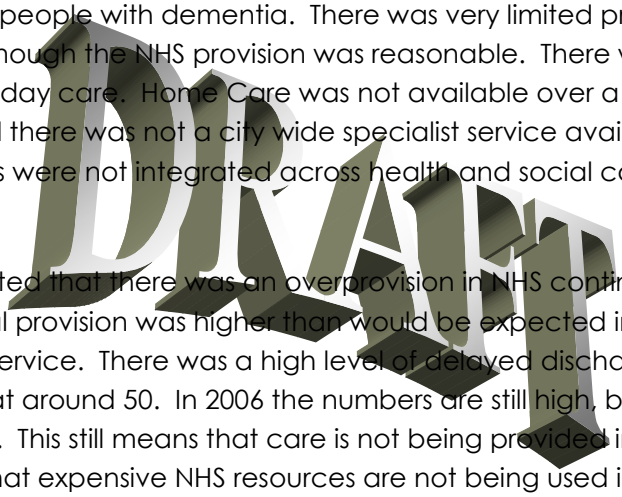
The current Intermediate Care services will offer a service to someone with mental health needs, if their primary need for rehabilitation is for a physical condition. There is interest in both the PCT and the Council in looking at whether a more specialist service for people with mental health needs would be beneficial.

Transitional care has offered older people, their families and care managers a service which allows them to be discharged from hospital safely and quickly when there are concerns that they will not be able to return to living independently at home. It allows time to undertake a more through assessment and explore any opportunities to provide care at home. The reduction in both delayed discharges and residential admissions shows this. The current provision does not offer a dementia service however.

Mental health services

It is clear that increasing numbers of older people with dementia will be a key pressure for the whole health and social care system. There are elements of service that are not fit for purpose now, and so we risk major issues over the next 15 years as the demographic pressure increases the demands for EMI services.

The Dementia North report in 2001 highlighted that there was a shortage in specialist residential and nursing home places in York, and a lack of specialist supported housing for people with dementia. There was very limited provision for social care respite, although the NHS provision was reasonable. There was only a small volume of social day care. Home Care was not available over a 24 hour period at this time and there was not a city wide specialist service available. Care pathways and services were not integrated across health and social care.



The report also suggested that there was an overprovision in NHS continuing care beds, and day hospital provision was higher than would be expected in a community focussed service. There was a high level of delayed discharges. In 2001 this was running at around 50. In 2006 the numbers are still high, but have reduced to around 35. This still means that care is not being provided in the best place, and it means that expensive NHS resources are not being used in the most effective way

Following on from the Dementia North report in 2001, there is agreement between the Council and the PCT that the current service patterns for older people with mental health problems would be improved if resources could be increased in community based care, and care pathways could be more integrated. Some of issues have been addressed in part since 2001, with the development of two Council homes to provide EMI care, the opening of a new nursing home with 40 EMI beds, and the development of overnight care and a city wide specialist EMI home care service.

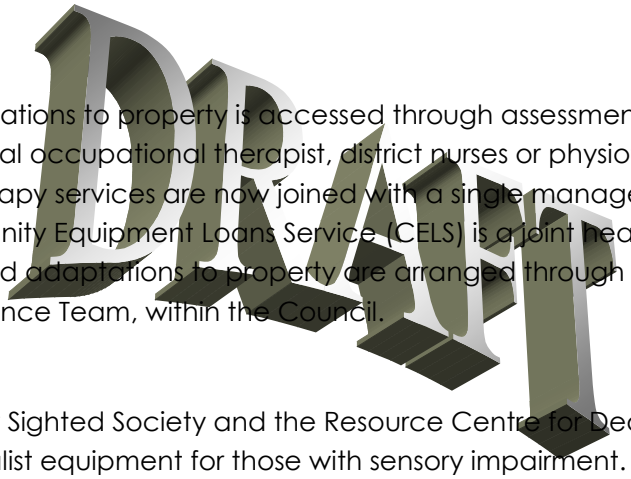
One Community Unit (CUE) has been decommissioned over the last year, and resources reinvested in one of the PCT's community teams, to provide more intensive and extended hours of support outside of hospital.

Work is continuing between the PCT and the Council to look at how further changes can be agreed and managed. There is an active debate on how to improve integration, without isolating mental health services from mainstream social care provision for older people.

As highlighted in the section on Intermediate and Transitional Care, there is the potential to develop both intermediate care and transitional care for older people with mental health needs. The services now in place do not exclude people with mental health needs, but do not cater for those whose primary need is mental health.

Equipment

We achieve good performance in the delivery of equipment, but demand for OT and equipment services is high and waiting times for an assessment can lead to delays.



Equipment and adaptations to property is accessed through assessment by either a community or hospital occupational therapist, district nurses or physiotherapists. The occupational therapy services are now joined with a single management structure. The Community Equipment Loans Service (CELS) is a joint health and social care service, and adaptations to property are arranged through the Housing Regulation and Assistance Team, within the Council.

York Blind and Partially Sighted Society and the Resource Centre for Deafened People provide specialist equipment for those with sensory impairment.

There are a number of retailers who sell aids to daily living within the city. Our links with these providers is limited at present.

In 2005/6 94% of items of equipment and adaptations were delivered within 7 working days of the order being placed, and the average length of time waiting for minor adaptations from assessment to work beginning was 1.4 weeks. Major adaptations took on average 22 weeks. Times taken for adaptations was an improvement on previous years, with the time taken reducing from 5 weeks and 36 weeks.

There are discussions ongoing on how to revise access to services and whether the development of a Centre for Independent Living should include a demonstration centre and web-based access for individuals, to provide better information about what is available and what it can provide help with. The Council has made a bid to the Department of Health for funding to develop self assessment for more simple equipment, to free up time to reach the more complex assessments quicker.

Day care services

The Best Value Review identified five years ago that capacity within day care services needed to be increased by 10%, based on the demographic projections of a 10% increase in population between 2000 and 2005. This is the one area from the Review that has not been acted upon, because of capacity issues and other priorities

We know there are quality issues with the day care, provided in our residential homes for up to 70 people a day. The care is not adequately resourced, with only two homes having dedicated space within the home for day care customers and does not meet CSCI standards. Customers are kept safe, and the service provides respite for carers, but the range of activities is limited.

The Dementia North report highlighted the gaps in service for social day care for people with mental health needs, and the overprovision of day hospital places. The PCT have worked with Age Concern' to provide more social day care in the CUEs, and day care is now provided 2 days a week at Beckside in Fulford, for up to 8 people a week but there is still a limited availability of day care for people with EMI needs.

Day clubs within the voluntary sector are popular but are increasingly finding they cannot meet the care needs of those who attend or wish to attend. Approximately 1015 customers a week attend clubs run by Age concern and APS. Some day clubs have vacancies a well as waiting lists, because they cannot always provide transport for those who need it

Support to Carers

Of the 607 carers identified in the year to March 2006 as carrying out substantial and regular care, only 86 accepted a separate assessment of their needs.

Even at this low level there are reports of delays in the assessment process for carers, and this will need to be addressed if we are to reach and support carers at the right time to offer support.

The level of carers' assessments is expected to increase this year, with the number completed by the end of August already exceeding the total for last year. The introduction of a Direct Payment scheme for carers has been very popular, with over 40 people using the option between April and August 2006.

Carers have said they would like more services to be available to provide respite care within their own homes. We have begun to address this is in a small way with additional hours in the overnight care team specifically for carer support

Direct payments

We have a very low take up of direct payments. The 2005/6 PSS survey asked older people about direct payments. The main reason preventing people from using direct payments was because they did not understand what direct payments is

about (29%), with 13% saying they thought it would be too much hassle to apply. However 28% said nothing would prevent them.

Heath care

In order to deal with the growing demand on secondary care of people with long-term conditions, Selby and York PCT have developed multi-professionals teams (MPT) to provide a proactive and targeted approach to the management of individuals with ongoing health needs. Currently there are four MPTs across the PCT locality each consisting of a Community Matron, Physiotherapy and Occupational Therapy. The role of the Community Matron provides a means to intervene and prevent unplanned admissions through effective case management of those deemed at high risk.

A business case has been considered for a Falls Co-ordinator post in York, but it has not been possible for the` PCT to fund this initiative

Residential and Nursing Care

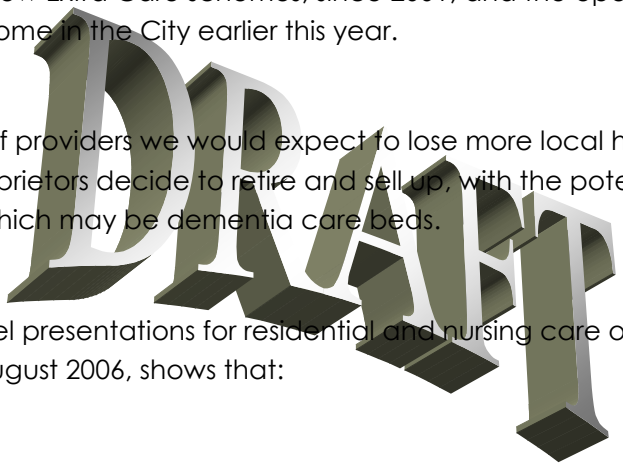
There are 17 Registered Care Homes in York, with a total of 575 beds. 9 of the homes are run by the Council. Four homes offer 91 beds for EMI care, including one CYC home. The Council is in the process of adapting a second home to provide specialist EMI care. Four other CYC homes provide specialist care alongside standard beds: one home currently has an Intermediate Care Unit, and three homes provide 'high dependency care', with additional input from community nurses to support care staff. The Intermediate Care Unit has been funded by the PCT but funding is to be withdrawn as part of the PCT's Financial Recovery Plan.

Nearly a half of the total residential beds in the city are provided by CYC. This is higher than some other local authorities, but it has provided a balance within the market when the independent sector has been more vulnerable, and has provided the opportunity to develop more specialist services with support from health professionals.

There are 13 registered nursing homes in the City, offering 695 beds, 254 of these for Emi care. 8 beds are registered for palliative care.

The Best Value Review anticipated that admissions to residential homes would decrease, but that those who need residential care would have increasingly complex needs. We have reduced from 113 admissions to residential care in 2001 to 75 in 2005. The highest demand is for EMI and 'high dependency' care.

We have lost capacity from the market over the last six years, in both residential and nursing care, with approximately 170 beds lost since 2001. This loss of capacity has been addressed through the reduction in numbers of admissions, the development of two new Extra Care schemes, since 2001, and the opening of one new 80- bed nursing home in the City earlier this year.



From our knowledge of providers we would expect to lose more local homes in the next 5-10 years, as proprietors decide to retire and sell up, with the potential loss of 50-60 beds, some of which may be dementia care beds.

An analysis of the Panel presentations for residential and nursing care over the two years August 2004 – August 2006, shows that:

- 31% (109) were primarily because of dementia concerns.
- 15% (52) were referred following strokes, and
- 11% (38) following falls.
- A further 31 people had confusion as a secondary issue, and
- A further 35 had secondary concerns about falls.
- 6% (21) were suffering from Parkinson's disease, and
- 6% (21) had mental health needs linked to depressions and anxiety.
- 50 of the 343 people considered had carers who were unable to cope. 16 of these were either ill or disabled themselves. And 11 were caring for people over 90.
- 12 people were diagnosed as needing terminal or end stage care, and 45 had to move from one home to another because their needs had increased.

Although we have adapted one of our homes and are in the process of adapting a second home to provide specialist EMI residential care, we struggle to find residential placements for people with dementia. There are over 35 people waiting in the community and in non acute hospitals for placements. As a result the equivalent of one further CUE (NHS provision) is being used for inappropriate care, at a much higher cost than necessary.

We currently have a waiting list of 9 people needing 'high dependency care' which allows people who do not need frequent nursing interventions, but do need for example two carers to provide frequent care tasks, to remain in residential care. It is planned that the capacity released by decommissioning of the Intermediate

Care beds at Grove House will be used to develop additional High Dependency beds therefore.

CSCI's Local Market Analyser indicates that residential homes in York generally meet around the national average of standards (76%), but that Nursing Homes in York meet a lower percentage of standards (59.3% compared to 74.1% nationally) than homes nationally.

One of the reasons the Council has retained its own stock has been to ensure that we can develop the required specialist care at a time when the market was fragile, and the independent sector was contracting. There is agreement that the future roles of the non specialist homes will need to be reviewed further.

The Council funds only approximately one third of the available independent sector beds within the city. There is a strong self funding market, and fee levels are higher than the regional average. Many independent sector homes will now accept City of York Placements only with a third party top up. York pays on average at the lower end of the regional average for fees. However the market rate for York is similar to areas in the south of the country, rather than the regional average for Yorkshire and Humber.

Increasingly this means that the level that York will fund for supported placements is below the fee charged by a home. This is limiting choice for some older people, if they cannot fund 'top-ups'. We are working slowly towards achieving a 'Fair Price for Care' having used the model from William Laing[5] to agree a local model with our local provider representatives, and will need to continue to do so.

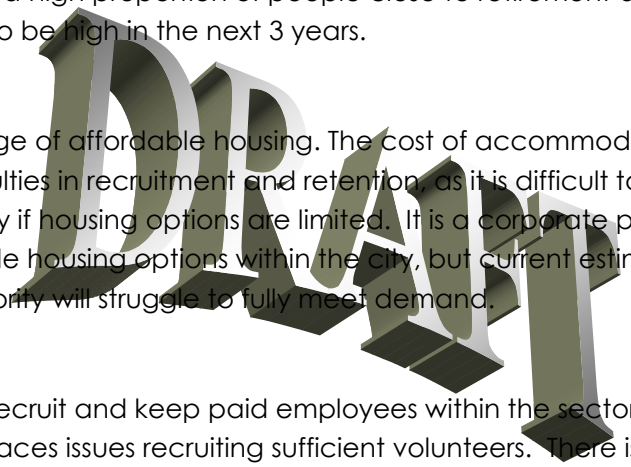
However the in house unit costs are still higher than the fees we pay for residential or nursing care and so we will need to keep in mind whether these costs can be reduced, or whether there are more cost efficient ways to deliver the specialist services that we are now providing within our homes.

Workforce issues

All providers struggle to recruit and retain staff. Competition over wage levels with other sectors, including retail and call centres mans that it is not easy to attract and keep staff.

[5] Calculating a fair price for care: A toolkit for residential and nursing care costs by William Laing 2004 The Policy Press

Over the next ten – fifteen years the demographic profile of York suggests that it will continue to be difficult to recruit staff. The working age population in the city is expected to decrease, as the older population increases. We know that our current workforce has a high proportion of people close to retirement age and so turnover is expected to be high in the next 3 years.



York also has a shortage of affordable housing. The cost of accommodation in the city adds to the difficulties in recruitment and retention, as it is difficult to recruit a workforce in to the city if housing options are limited. It is a corporate priority to increase the affordable housing options within the city, but current estimates suggest that the authority will struggle to fully meet demand.

Just as it is difficult to recruit and keep paid employees within the sector the voluntary sector also faces issues recruiting sufficient volunteers. There is a shared ambition with the voluntary sector to increase the contribution the voluntary sector makes to the well being of older people, but this will need capacity within the sector to be supported and increased

Responses

Therefore, it will be essential to make more effective use of the workforce available, and to ensure that there is no duplication of effort between services. Wage levels are already higher than some locations within the region and are likely to continue to rise as the available workforce reduces. Effective management of the workforce issues, and continued joint working with all providers and the Economic Development Unit for the city will need to be part of our commissioning activity

A number of residential and nursing care providers have recruited from other countries to fill the staff and skill shortages they face. This approach is understandable, but brings with it additional training needs, to ensure that standards can be met and maintained, and that communication between staff and residents is not compromised.

Summary of service analysis

- We have a good range of popular preventive services in the City, provided mainly by the voluntary sector. The lack of a Prevention Strategy means that sustainability, equitable access and capacity issues are not addressed systematically.
- We have an increasing lack of capacity in voluntary sector provided day clubs, this is exacerbated by the lack of transportation.

- There are some good health promotion programmes run by the PCT but we know these need to be improved and extended to encourage more physical activity, and thus improve health and well being.
- We have limited knowledge about the impact and outcomes from many community health interventions, but we know there are not sufficient podiatric interventions to meet demand.
- We have seen an increase in demand for property adaptations.
- York has a large supply of sheltered housing within the social rented sector, and there may be some over capacity, but the choices are limited for owner occupiers if they want specialist accommodation. The Council's warden call service offers an inclusive service to all tenures however, and is well placed to provide a first response service to new telecare ar
- Extra Care developments have helped to reduce the numb needing residential care, but these developments have so far been primarily in Council owned stock. There are areas of the city with high numbers of older people and no local extra care resource, and the options for owner occupiers/self funders are very limited.
- We believe that our reconfigured domiciliary care services will release capacity and funding, and ensure that older people are helped wherever possible to regain self care skills and independence but receive a service best suited to their needs if they need long term personal care.
- Intermediate Care bed provision is set to reduce over the next year, but together with the transitional care beds the service has contributed to very low levels of delayed discharges from the acute hospital. Further work is planned with the PCT look at both step up and step down services.
- Mental health services are not yet configured in the most effective way to deliver community based care and support, nor to make best use of the resources invested in mental health services. Consequently this means that for this particular group of older people we see that there is limited provision in transitional care, specialist residential and nursing home care, a lack of supported housing, limited social care respite, and small volumes of day care, a lack of 24 hour home care and a lack of a city wide specialist. Additionally we see a lack of integrated services across health and social care.
- We perform well in the delivery times for equipment, but could improve the waiting times for assessments.
- Day care services are overdue a comprehensive review. We know there are quality issues in some of the services we provide and we know some people are not able to access services because we do not have the right support in place.

- There is still a lot of work to do to ensure that carers needs are understood and met. If we do not do this we risk not supporting as many older people as possible to stay in their own homes for as long as possible.
- Demand for, and capacity within, the residential care sector is reducing. The pressures within the sector are for EMI vacancies, and 'High Dependency' residential care, and this is where City of York Council have been focussing development of their role within the market.
- There are high unit costs for in-house residential provision
- There is an overprovision of NHS continuing care and day hospital provision
- We predicted that there will be an on-going loss of capacity in residential and nursing home beds, particularly dementia beds
- A high proportion of those needing residential or nursing care are self funders.
- All services are already struggling to recruit and retain staff, and this is likely to continue to be the case.

Further Supply Data to be identified and the contribution this will make to the commissioning strategy

We believe that the above analysis helps us to form a good position statement on our existing service provision. However, in order to conclude our assessment of current services we will continue our evidence gathering to help us to form a view on the following:

- Do we have a good balance of service providers? For example, the independent and "third sector", large and small providers.
- Are our services suitably distributed geographically?
- Can we identify good examples of innovative service design and delivery and are they effective?
- Are our services "good quality" and do they provide value for money?

We feel that this work has been a first attempt at forming this picture and we acknowledge that we will need to re-visit this area if we are able to improve the quality of our analysis. For example we would like to look at each service and form clear statements about what quality is to be expected, on what is that based and how is it to be tested. Is there clarity about what the service is trying to achieve and is this based on outcomes or outputs? Therefore, we intend to pursue the following areas for evaluation:

- What are the best practice models of care and support in the community for older people with dementia across England, Scotland and Wales in the following service areas:

  - Home Care
  - Extra Care and Specialist Housing
  - Day Care

- What services/interventions for people with dementia extend an individual's stay in the community – for how long? How much do these cost? Who should they be aimed at?
- What are the current advances in medication and technology for older people with dementia and what is the affect of such?
- What do carers need/ want to enable them to continue with their caring role?

Annex 3

DRAFT Gap Analysis and the Design of Future Provision

This section spells out the shape of future services and the strategic priorities necessary to achieving them.

Stage 1 Future forecasting

We have identified in the Needs Analysis that, using demographic forecasting, we expect the older population in York to grow by 31% between 2005 and 2020. If no action were taken to reduce ill health within the population this would mean that we could expect the following increases in needs within the population. The following table shows the increase in numbers that might be expected for key conditions, based on a 31% increase in population.

Table 13: Summary of predicted increase in key conditions

Condition	Current numbers	2020 predicted numbers
Dementia	2,100	2,800
Diabetes	4,600	5700 (forecast for 2010)
Falls (more than 1 a year)	1,440	1,815
COPD	1,100	1,604
Stroke	150	200
	9,390	**12,119**

We have some information to help us understand where in the health and care system these conditions are most likely to produce pressures.

We do know that in 2005/6 there were 453 people over 65 receiving social services, who were identified as having primarily mental health needs, and that 287 of these were identified as having dementia. This would suggest that we are currently meeting only 14% of the possible demand for dementia care and support. If we were to continue to support the same proportion in 15 years time we would need to provide care for an additional 163 with mental health needs by 2020, 105 people of these additional customers would have dementia

We also know that 4,698 people over 65 receiving services from the Council were identified as having physical disabilities, with 4,170 of these living in their own homes. If these increased at the same rate we would need to support and additional 1,456 people in residential or nursing care or in their own homes

If demand, type and proportion of service provision remained constant this would mean that we would expect to need to provide an additional 31% volume on top of the current services. The following table shows the impact of increasing current capacity by 31%. The projected costs for 2020 do not include any allowance for inflationary uplifts, and are based on the current investment by City of York Council only.

Service	Current numbers per annum	Current cost	Projected numbers per annum	Projected cost
Home Care	2120	£6m	3108	£8.9m
Equipment	2390	£0.55m	3582	£0.8m
Residential and nursing care	995	£9.5m	1428	£13.6m
Total		£16.05m		£23.3m

Stage 2 Conclusions

Our assumptions about population growth have been based on demographic projections. We recognise that there is a risk that the older population will grow faster than the demographic projections predict particularly if new private sector housing developments attract 'incomers' as expected. Although the majority might be owner-occupiers and able to fund their own care needs, there would still be an additional pressure on health services, and on workforce availability

Healthy life expectancy will be influenced by the success of health improvement programmes. In 2004 the Department of Health published 'Choosing Health – making healthier choices easier' which identifies priorities for local health agencies and their partners to reduce the incidence of key conditions. Locally there are initiatives working to reduce the incidence of coronary heart disease, strokes, and diabetes. Reductions in incidence of these illnesses, and improvements in the management of symptoms could reduce demand for services in both the health and care services. Additionally, The lack of long term funding for a Falls Co-oordinator is see as a risk to address demand in this area. We do not know how these conditions impact on the demand for services currently and so it is difficult to factor in any impact on demand through reduction in incidence of limiting conditions on demand for services.

We have limited knowledge about the use of and demand for other preventive community health services or the impact that either their presence or absence has on social care provision. Generally services are not provided specifically for older people, and health information is not available on locality basis, or a patient basis. Practice Based Commissioning could help to give a better understanding of the role these services can play in reducing demand for more intensive health and social care services.

Preventative services such as Day Clubs are finding that a growing number of the people who are interested and would benefit from the social interaction of the

clubs cannot be accommodated because they have personal care needs that the clubs are unable to meet, or transport to get them to the clubs is not available.

There is an assumption, nationally and locally, that the introduction of telecare and telehealth monitoring will reduce the demand for more traditional services, both community based and residential care. The ability to monitor risks 24 hours a day will offer a new choice for people to remain safely in their own homes, and will allow help to be provided when a crisis occurs, rather than rely on help being summoned (as with the current community alarms), or identified only when a visit is made. The impact of this will, it is assumed, mean we would expect to be able to use some of the resources currently funding 'pop-ins' to provide more intensive care packages for those who need to be helped with personal care at home. It is also assumed that we could further reduce the number of people needing residential care, because we could manage risk more consistently.

It is clear that dementia services will be increasingly under pressure as the population grows. Models that have been seen to be effective in adult mental health services are assumed to offer potential benefits to older people as well. 24-hour cover by integrated community teams; rapid response, and community crisis teams would help to reduce the number of older people needing hospitalisation to undertake assessments. Improved support to carers at an earlier stage would, we believe, allow us to support more people to remain at home for longer

The authority believes that to support improved target support to older people at home would be enhanced by moving all the new domiciliary services to outcome based contracts from the outset, but decided we have not completed the necessary work to introduce this yet.

As generic services (home care, day care, care homes, sheltered housing) play a very important part in providing quality of life for older people with mental health problems, such as dementia and depression, and in preventing unnecessary admissions, it could be assumed that staff in these services require additional support to develop mental health skills.

The Dementia North report suggested that the numbers of older people needing support because of dementia would be affected by the growing use of anti – dementia treatments. At this stage we still cannot estimate accurately the impact of the treatments. There will still be a need to monitor the health and needs of anyone receiving such treatments, even if the demand for more intensive support can be delayed through their use.

We made assumptions through the Best Value review that additional extra care, provided it is linked to a 24 hour service for personal care needs, will reduce the demand for residential care. The evidence suggests this was true, as the demand for residential care has been decreasing. We would assume therefore that if we can continue to develop specialist and comprehensive services within the

community (Intermediate and Transitional Care) we can at least stabilise, if not reduce further the demand for residential care as the population continues to grow. We would expect that where there is a need for residential care it is most likely to be for EMI and high dependency needs, but would wish to explore models for extra care that could offer an alternative to older people with the most complex needs.

There is a limited choice of suitable housing in the private "to buy" sector. The authority is aware of growing interest from developers and we have seen a number of planning applications for sheltered schemes for home owners. This is something we would want to encourage, but currently have concerns that the models of development being proposed do not address affordability issues

The authority and its partners need to improve their approach to understanding demand and supply. The new York and North Yorkshire PCT is beginning to look at how to commission better services to address high levels of unplanned hospital care of older people. This will be within an agreed commissioning framework, which will involve both local authorities. There is clear potential for improvements in both step up and step down services, to reduce hospital admissions.

Crucial to this understanding of our current position is the need to do more to identify and assess carers at the right time to offer support.

Stage 3 Funding

York is a low spending council, with a low tax base, and low grants settlement. Unless any of these factors change over the next 15 years, there will be significant funding pressures created by the need to continue to achieve efficiencies at the same time as demand is growing.

The Primary Care Trust is also subject to severe financial pressures, and has just published plans to address a £23m shortfall in budget for this year.

If it should be necessary to change eligibility criteria it is expected that some of the savings achieved would be used to reinvest in preventive services. All of the voluntary organisations currently funded are interested in opportunities to increase their capacity.

Home care budgets have overspent for the last two years. We believe the new service configuration will bring efficiencies, both because of the changes in working practices and because of the greater focus on enabling outcomes and specialist provision. We would expect to be back within budget next financial year, but it will be essential that in house services deliver the expected efficiencies to increase the proportion of direct contact time provided.

The Supporting People funding is expected to continue to fall, possibly throughout the next 10 years. We know that York has been considered to be one of the 'outlying' authorities, whose legacy funding at the inception of the programme was considerably higher than a distribution formula would probably allocate to the city.

A growing number of homeowners would suggest that more people might be able to afford to fund their own care in future. However there is a risk that the traditional employment patterns in York will mean that many may be capital rich but revenue poor. Until recently York's traditional industries had been the railways, manufacturing, retail and tourism, and these traditionally have not provided high pension levels.

Currently Supporting People only funds services for tenants. Although any Supported Housing Costs for owner occupiers are allowed within a Fairer charging assessment for social care services, someone just receiving a warden call service for example would not be eligible for a subsidy, whatever their income level. With an expected growth in the number of owner-occupiers over the lifetime of this strategy, we will need to review the implications of this, for achieving the outcomes of supporting more people to remain within their own homes.

There are still opportunities to deliver efficiencies in service delivery and costs. Home Care has already been mentioned. We know from the Dementia North report that there is potential to remodel some of the current mental health services for older people to provide more community based support, more cost effectively. We have not yet conducted the planned review of day care, and we will need to ensure that the big investment that we currently have in the in house residential care homes is the best use of funds, particularly if the introduction of telecare and telehealth monitoring, with the appropriate response services, can deliver the benefits predicted, and reduce the demand for residential care.

Our Hypotheses

Based on the above predictions and assumptions we have constructed hypotheses that will form the basis of our on-going data collection and evaluation and the development of our future commissioning priorities:

"If we transfer services from hospital-based (secondary) care to GP (primary) and intermediate care for older people we would be able to increase the number of people who are supported at home and reduce demand for acute hospital based beds. Specifically we could develop specialist home and day care services."

Additionally;

'Continued investment in extra care housing will allow us to reduce the number of residential and nursing beds we purchase or provide.'

"We need to remodel some of the current mental health services for older people in order to provide more community based support, more cost effectively.

"The introduction of telecare and telehealth services, with the appropriate response services will provide good service user outcomes and reduce the demand for residential care".

"An increase and targeting of resources and support to carers (especially those caring for older people with dementia) will contribute to maintaining someone in the community and minimise the risk of the carers ill health and in-ability to care"

Stage 4 Commissioning Priorities

In order to test out the robustness of these hypotheses into service developments is to focus on service provisions and interventions that we believe is most likely to have an impact on these assumptions:

- Development of shared commissioning framework with health. This will include agreement on what information should be regularly collected, and how it will be analysed and shared, to inform decision making about services. Greater understanding of the effectiveness and impact of health interventions and improvement initiatives on demand for services
- Dementia Care – Increase in capacity in services to meet the growing need for services. Focus to be on development of more community based health and social care, including more intensive and crisis response services, and more support for carers. Development of more integrated working, and improved support at GP practice level.
- Increased capacity to provide care at home, including those with more complex needs on a 24 hour basis
- Effective use of telecare and telehealth monitoring to deliver more choice, and more independence, with improved management of risk at home.
- Development of a Prevention strategy, to shape what services we would wish to see available, ensure best use is made of resources to support more people at an earlier point in their care pathway, and to reduce social isolation.
- Reshaping of day care services to provide more effective respite care, and to allow those with health and personal care needs access and choice in day time activities
- Improved and targeted information, which proactively looks at what services, support, and opportunities for community involvement might be helpful to people, and in particular carers.
- More integrated working, between health and social care, with improved links to GP practices.

- Work with housing providers from all sectors to further develop Extra Care model of housing, including growth of care services around current sheltered housing schemes, and development of dementia care models within specialist housing options
- Work with Planners to ensure that best use is made of opportunities to develop new housing for older people, taking into account changing tenure patterns, need for affordability and likely levels of demand from York residents.
- Workforce issues will need to be addressed across the system to encourage and support recruitment and retention within the care sectors, and to maximise efficiencies through more integrated working.

Our next step in developing our plan of how we will begin to move to this position is to undertake a cost benefit analysis in order to establish the following:

- Which of these services already exist, what impact would increased take up have on its capacity to deliver and at what cost could the service be increased?
- Which services would need to be created or adapted and at what cost?
- Which services might be de-commissioned or reduced in size as a consequence of new interventions?

CS2308

Meeting of the Executive Members for Housing & Adult Social Services Advisory Panel

15th January 2007
CS2308

Report of the Director of Housing & Adult Social Services

Review of Non Residential Charging Policy

Summary

1. This report recommends that the Executive Member agrees an updated charging policy for non residential care services subject to approval of the 2007/08 budget by the Executive in January.

Background

2. Following consultation the Government issued extensive guidance on fairer charging policies for home care and other non residential social services in August 2002. Although the guidance set out a clear policy framework it still left large areas of discretion for local authorities in terms of the detail of charges to be made. Non residential care services include home care, day care, transport, meals in day care and laundry.

3. The council adopted it's current policy, which is fully compliant with this guidance, with effect from April 2003.

4. All customers who receive non residential care services are offered a benefits check to ensure they are claiming all the benefits to which they are entitled. Information is also collected on savings and other outgoings, eg rent and council tax, to assess how much the customer can afford to contribute towards the cost of their service. No customer will be asked to pay more than they can afford.

5. There was no comprehensive policy document issued alongside the changes made in 2003 which covered all the aspects of charging for non residential social services and this has occasionally caused difficulties for both staff and customers due to the lack of clarity about how their charge has been calculated.

Consultation

6. A meeting was held on the 15th December 2006 with a number of representative bodies where these proposals were discussed.

Options

Option 1

7. To agree the updated non residential charging policy as attached at Annex 1.

Option 2

8. To not agree the updated policy and continue with the current situation where there is no formal policy document that can be shared with customers.

Analysis

9. The main changes included within the revised policy are set out in more detail in the following paragraphs.

Charging on planned care

10. The policy includes the potential for the council to charge the customer on the basis of their agreed care plan. The advantage to the customer is that it enables them to plan their expenditure and use a bank standing order to set up regular payment for their care. Where the actual care delivered is different to the plan – eg where the customer goes on holiday or into hospital for a period of time, an adjustment will be made to reflect this and their charge amended accordingly. The advantage to the council is that it is administratively more efficient. This change would not be introduced until November 2007 at the earliest when the new social care IT system has been implemented.

Disability related benefit disregards

11. The current policy is to disregard 50% of any disability related benefits, eg attendance allowance and disability living allowance, which equates to anything from £20.28 per week to £63.07 per week depending on the severity of the customers disability. The new policy proposes this disregard is reduced to 35%, which is anything from £14.20 to £44.15 per week. The results of a nationwide benchmarking exercise show that most councils take 100% of these benefits and ask customers to demonstrate that they have disability related expenditure over an above normal day to day expenses. They also require that this is backed up with official receipts. The average amount allowed for disability related expenditure in these authorities is just £10 per week.

12. Under the revised policy customers will still be able to request an assessment of the disability related expenses if they feel that they are over an above the

standard allowance made. To assist with this process clarification has been given on disability related expenses and the allowance the council will make.

Clarity of policy

13. The revised policy should now provide clarity on a number of issues including
    - the treatment of partners
    - backdating of the calculation of the charge following a change in customer circumstances and
    - debt recovery

Corporate Priorities

14. The changes outlined in this report have been focused on two main areas. Firstly to try and improve the information available to customers, to ensure they are fully aware of the council's policy on charging and how it may effect them. Secondly to focus on ways to improve the efficiency of the charging service and reduce waste.

Implications

- **Financial** The changes proposed in changing the disregards given for disability related benefits will generate additional income for the council of approximately £244k. This has been included within the budget papers to be considered by the Executive in January and the Budget Council in February. Any agreement to the revised policy by the Executive Member at this meeting will be subject to approval of the proposed budgets for 2007/08.

- **Human Resources (HR)** There are no HR implications.

- **Equalities** The policy contains a diversity and equality statement and also ensures that appropriate and relevant expenditure related to a customer's disability is taken into account during the financial assessment.

- **Legal** No legal implications are anticipated as the revised policy is in accordance with the Government guidance. The policy is currently being examined in detail be colleagues in legal services and a verbal update will be given at the meeting should any problems have been identified.

- **Crime and Disorder** There are no crime and disorder implications

- **Information Technology (IT)** There are no immediate IT implications. Should the revised policy be agreed then it will need to be incorporated into the replacement social care system to ensure the policy can be delivered effectively and efficiently.

- **Property** There are no property implications

- **Other** There are no other implications

Risk Management

15. Should the revised policy not be agreed there remains a risk that the council is not collecting all the monies due to it or that customers are paying more than they should for services. If the current lack of clarity around the policy is not resolved there may also be an increase in the number of complaints in this area. Agreement to the revised policy will remove these risks.

Recommendations

16. That the Advisory Panel advise the Executive Member to:

    - Agree option 1 and the introduction of the revised non residential charging policy with effect from April 2007 subject to the agreement of the budget proposals at the Executive in January and full budget council in February.

      Reason: To ensure clarity and equity for customers and to ensure the department has a balanced budget for 2007/08.

Contact Details

Author:
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Chief Officer Responsible for the report:
Bill Hodson
Director of Housing & Adult Social Services

Report Approved ✓ **Date** *29/12/06*

Report Approved *tick* **Date** *Insert Date*

Specialist Implications Officer(s) *None*

Wards Affected: *List wards or tick box to indicate all* **All** ✓

For further information please contact the author of the report

Background Papers:

Fairer Charging Policies for Home Care and other non residential Social Services – Dept of Health, September 2003.
Social Services 2007/08 service plan and budget report – HASS EMAP, 11th Dec 2006.

Annexes

Annex 1 – City of York Council non residential charging policy

Annex 1

CITY OF YORK COUNCIL

DRAFT Charging policy for non-residential care services

Contents

Annex 1

Introduction to the City of York Council's charging policy for home care and other non-residential care services

This document sets out the City Council's policy for charging customers who receive care at home and other non-residential care services following an assessment of their individual need. The current policy was effective from 1st April 2007 and is compliant with the Government's guidance "Fairer Charging Policies for Home Care and other Non-Residential Services".

This policy also applies to the assessment of charges for Supporting People services where service users are not passported by virtue of claiming and receiving Housing Benefit.

1.0 Legal basis

1.1 Section 17 of the Health, Social Services and Social Security Adjudication Act 1983 gives local authorities discretionary power to charge adult recipients of day and domiciliary care services.

1.2 To ensure consistency and fairness, the Department of Health has issued guidance "Fairer Charging Policies for Home Care and other Non-Residential Services" using powers conferred under Section 7 of the Local Authorities Social Services Act 1970.

2.0 Diversity and equality

2.1 The council is fully committed to the broad principles of social justice and is opposed to any form of discrimination and oppression. It therefore willingly accepts not only its legal responsibilities but also wishes to embrace best practice in all areas of its work in order to secure equality of both treatment and outcome.

2.2 The council is committed to ensuring that no one is treated in any way less favourably on the grounds of personal differences such as age, race, ethnicity, mobility of lifestyle, religion, marital status, gender, sexual orientation, physical or mental impairment (disability), caring responsibilities and political or other personal beliefs.

3.0 Policy aims

3.1 The City Council's charging policy has been designed to comply with the Government's fairer charging guidance. Its aim is to provide a reasonable and fair charging framework for all service users. The income generated from the charges helps maintain and develop services for vulnerable people.

4.0 Definition of non-residential services

4.1 Examples of the services covered by this policy include:
- Home care
- Attendance at day centres
- Transport to day centres

5.0 Principles

5.1 The principles underpinning the charging policy are:

- Generating income from charges is essential to maintain and modernise our services.
- The charges levied on customers are aimed to be fair and reasonable. Due care will be taken in assessing the customers finances and their ability to contribute towards the cost of their care according to their means.
- The charges should be easy for customers to understand.
- Integrating all charges will ensure a customers income stays above the levels set out by Central Government.
- A financial assessment offers the customer the opportunity to lower their charges. The financial assessment will ensure service users net incomes will not be reduced below the basic level of Income Support and/or Pension Credit plus a 25% buffer.
- The council will provide appropriate benefits advice and assistance in order to maximise our customer's incomes and improve quality of life and combat dependency.
- The costs of disability are recognised by our policy.
- Customers who work or wish to work will not have their earnings assessed as part of their financial assessment.
- Getting our financial assessment right first time will improve the service as well as helping the customer to understand the scheme and reduces the likelihood of loss of income to the council.
- Decisions about the provision of services will be taken independently of financial circumstances.
- Customers have the right to ask for a review of their charges if they consider the charge is unfair, or if they feel that they cannot pay the charges.
- Customers who refuse to pay their assessed charge will not have their services withdrawn. The council will recover arrears from charges in a sensitive way where service users clearly have the ability to pay but refuse to do so, taking legal action as necessary but only as a last resort.
- All customer financial information (verbal and in writing) will be treated in confidence, and due care will be given to disclosing information that is in the interests of the customer only.
- A customer who declines a financial assessment will be assumed to be able to meet the full contribution of their care package and will be charged accordingly.
- Charges will be based on planned care with regular adjustments to reflect any variations to the actual care received. Customers will be encouraged to establish methods of regular payment.

6.0 Charging Review

6.1 Government guidance recommends that local authority policies are reviewed annually and are subject to consultation with customers.

6.2 The Council reviews its charges annually and the latest charges are set out in appendix E.

Annual Financial Review

All charges and the charging policy will be reviewed annually in accordance with Government guidance.

There will be a rolling programme of annual reviews carried out (without a home visit unless thought necessary) of customers charges unless there has been a review within the last year due to changes in financial circumstances.

At any time a customer or their carer / representative can request a review of the charges.

Savings and capital limits will be maintained in line with changes in Charges for Residential Accommodation Guide (CRAG).

Backdating of changes

Customers income will be re-assessed in line with variations in the values of benefits as and when these values change. Expenses will be reviewed as and when changes in charges are made due to council tax variation or housing rent changes. Any changes in the assessed charge will be backdated to the date of the change in the customers financial circumstances. Where the customer feels they are unable to pay any backdated increase they are able to apply for a waiver under the appeals procedure outlined in Appendix B.

7.0 Procedures for charging

7.1 Day Care Meals service, Warden Call and Laundry
Customers who receive day care meals, warden call or laundry services are not financially assessed. They will be required to pay the set charge as outlined in appendix C as the charge constitutes ordinary living costs.

7.2 Home Care, Day Care and Transport
Customers assessed to receive Home Care Day care and / or Transport services will be referred by care managers to the benefits advice team for a benefits check. The advisor will collect financial information to be used in a financial assessment, which will determine their ability to pay a contribution towards their care. If they refuse to disclose their financial circumstances or do not complete a financial assessment within the given time period they will be asked to pay the full charge. Information explaining the charging guidance will be left with the service user by the care manager.

Benefits advisors will arrange a visit to the customer (or their financial representative) to complete a financial assessment form and conduct a welfare benefits check to encourage take up of benefits to maximise the customers income as well as maximising the income to the council.

In addition to advice about entitlement, staff will also help with the completion of benefit claim forms if the customer wishes.

Treatment of Income

All customers income and savings will be used in the assessment calculation with the exception of the following disregards:-

- All earned income
- Some housing costs

- Tax credits
- All war disablement / war widows pensions
- DLA mobility component
- DLA care component in full only where Independent Living Fund is being paid
- The value of compensation payments as detailed in CRAG will be disregarded indefinitely

The council may request written evidence of any income, expenditure or other assets declared as part of the financial assessment.

Customers will be asked to sign a form to authorise the Council to obtain benefits information from the Department of Work and Pensions, Jobcentre Plus, Disability Benefits Centres, Pensions Service and the council's benefits section.

Treatment of Savings

Savings will treated on the same basis as CRAG (Charges for Residential Accommodation Guide) where customers with capital over a certain amount will be charged at the prevailing hourly rate for the service received. The current figures are included in Appendix E.

Deprivation of assets

Deprivation is the disposal of a capital asset (both property and investments) in order to avoid or reduce care charges. There are currently no deprivation issues for non residential care charges. However if a customer is considering gifting or transferring any capital assets, this may affect their eligibility to receive public funding of any future residential/nursing care. We would recommend that the customer seek independent legal advice prior to taking this course of action.

Disability Related Expenditure (DRE)

The council will disregard 35% of the middle rate Disability Living Allowance (DLA) care component or the lower rate Attendance Allowance, together with 35% of the severe disability premium when in payment to take account of disability related expenditure.

Customers are entitled to request an individual assessment of their disability related expenditure (DRE) if they feel that the payment of their assessed charge would cause financial hardship. Guidance on DRE is attached at Appendix A.

Basic Income Level

The assessment of charges will ensure that the customer's net income will not be reduced below the basic level of Income Support and / or Pension Credit Guarantee, plus a 25% buffer.

Treatment of Couples / Partners income and assets

For the purposes of this policy a service user will be financially assessed on their sole income, capital assets and disregards. However if there are savings and capital held jointly with a partner it will be assumed that 50% belongs to the social

care customer unless proven otherwise. A couple is defined (for administration of their financial affairs) as two people living together as spouses or partners.

Number of Care Staff

If a customer requires two care staff to carry out a care task, the charge will be based on the amount of time care is provided, and not the number of carers. For example ; Service users receive 10 hours of care per week provided by two carers at the same time – i.e. 20 hours total. The charge will be based on 10 hours per week.

Direct Payments / Individual budgets

Chargeable service users in receipt of direct payments or individual budgets (rather than provision of equivalent services) are financially assessed in the same way as other service users. The amount of the direct payment is reduced by the amount of the calculated charge and the payment is therefore made net.

Non disclosure of financial information

Customers will be asked to disclose full details of their financial circumstances in order for a financial assessment to be conducted. They have the right to withhold consent for this disclosure, but if they do so, this will be considered as formally declining their right to be financially assessed. A customer who declines a financial assessment will be assumed to be able to meet the full contribution of their care package and will be charged accordingly. If a customer later asks for a financial assessment, an assessed charge will be applied from the date of the financial assessment and not the start date of the service.

8.0 Notification of charges

8.1 Details of the charge will be sent to the service user in writing after all relevant information has been provided. Charges will commence from the date the service user is notified in writing. If they are unhappy with their charge then they will be informed of the appeals procedure they can follow (see Section 9).

9.0 Appeals procedure

9.1 Any customer who feels that the payment of their assessed charge would cause financial hardship may request a review of the charge.

9.2 They must first contact their care manager to explain why they feel they are unable to pay their charge and to provide documentary proof of this. The care manager will request a review of their charge by the finance team. If they are satisfied through the review process that the customer is unable to pay, the care manager can (if they think it is necessary) refer the customer's request to the Head of Adults Services.

9.3 The Head of Adults Services will consider the request and either reduce, waive, or uphold the charge in accordance with Section 17 (3) of the Health, Social Services and Social Security Adjudications Act 1983 (HASSASSA Act 1983). Any decision to waiver will be reviewed on a regular basis.

The appeals procedure is attached – Appendix B.

10.0 Debt Management

10.1 The management of outstanding debt will be done in a sensitive manner and, as necessary, in a progressive manner with court action used as a last resort.

Stage 1 : Where payments are outstanding for over four weeks.

Internal checks will be made to ascertain that the care services have been provided.

Verification that the financial assessment was confirmed in writing will be made including that the customer and / or carer agreed to pay for the care services.

Checks will be undertaken to determine if the customer and / or carer have notified the council of any payment-related problems.

Personal contact with the customer and / or carer will be made to check that the weekly charge and outstanding debt recorded is correct and up to date i.e. check for actual provision of service, payments in transit or mis-recorded.

Enquire from the customer for any reason of non-payment. Determine whether the non-payment is temporary or that the customer has a problem relating to either paying or the care services provided.

Where the customer's financial circumstances have changed a new financial assessment will be undertaken. Any new financial assessment agreement will be confirmed in writing.

Stage 2 : No positive response

This stage starts if there is a lack of or insufficient response to the first stage of action and a further period of three weeks has elapsed. Personal contact will be made with customer and / or carer to determine why the previous agreement has not been complied with. Again verification that the information held is correct will be made.

Discuss with customer and / or carer regarding possible recovery actions available to the Council. Issue a letter setting out possible actions available to the Council.

Stage 3 : Final warning

After a further three weeks have elapsed and where payments are not being received. Again make personal contact with the customer and / or carer to ask for reasons for non-payment

Remind the customer and / or carer of possible recovery actions that might be undertaken.

Issue a formal final notice in writing to the customer and / or carer that formal debt recovery action will be undertaken if payment is not received within 15 calendar days.

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Stage 4 : Court Action.

If payment still not received after a further 15 calendar days. The council will issue a written notice to the customer and / or carer that court action will be taken if payment is not received within 10 calendar days. If after 10 days payment has still not been received refer the matter to Legal Services for County Court action to be taken.

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Appendix A
Charges for non-residential care services
Disability related expenditure 2007/08

This form may be used as part of your financial assessment to help us assess how much additional expenditure you incur due to your disability. The overall aim is to allow for reasonable expenditure needed for independent living. The following information is intended to help you think about your expenses. Please go through this information with the care manager when they visit you. They will help you through the process.

Note:

The items listed overleaf cannot possibly include all the disability related costs that apply to each individual customer. It is only a guide. It is expected that customers who qualify for the full range of allowances will be in the minority.

Annex 1

Guidance Notes

Fuel and heating

The rates shown below are based on average heating costs for properties in this area. They are inflated annually based on the latest RPI Fuel Index figures published by the National Statistics Office.

If you can prove that you spend more on fuel and heating (due to your disability) than the following allowances and can demonstrate why, we may take your additional expenditure into account:

Fuel costs - any amount of household fuel costs over and above that of the rates identified below for relevant accommodation type			
Accommodation type	Annual cost	Monthly cost	Weekly cost
Single people in flats and terraced housing	£584.00	£48.67	£11.23
Couples in flats and terraced housing	£769.00	£64.08	£14.79
Single people in semi-detached housing	£619.00	£51.58	£11.90
Couples in semidetached housing	£815.00	£67.92	£15.67
Single people in detached housing	£753.00	£62.75	£14.48
Couples in detached housing	£981.00	£81.75	£18.87

Community alarm

Subject to this being an assessed need, we will allow the actual cost, unless already paid for by Supporting People Grant.

Privately arranged personal care

Your care manager will need to assess whether this help is needed, and is not already included in the care the council provides. If your care manager confirms this requirement the actual cost will be allowed.

Private domestic help

We do not allow for domestic help costs.

Holidays

We do not allow for holiday costs.

Laundry

You may incur additional laundry costs as a result of your disability or illness. We will allow £2.81 per week if your laundry needs exceed four loads per week. This allowance includes the cost of specialist washing powders.

If you qualify for the laundry allowance we will also allow the cost of buying replacement, or additional sets of bedding, which is subject to wear and tear from frequent laundering. The allowance will be based on any reasonable expenditure incurred over and above the normal replacement cycle for bedding. We have estimated this cost at £40 per annum (i.e. we will only allow expenditure in excess of this).

Clothing
You may incur additional clothing costs due to abnormal wear and tear, or the purchase of specially made or adapted items for your disability. Any allowance we make will be discretionary.

Diet and food
Allowance for the cost of **special dietary needs** will be discretionary, as they may not exceed normal expenditure. The cost of freezer meals equates to everyday living costs and should not be regarded as an exceptional expense. We may use the Government's Family Expenditure Survey data to assess excess expenditure on food items caused by illness or disability. The threshold figures for normal food costs are:
One person retired household, mainly dependent on state pensions:
£25.04 per week
Two person retired household, mainly dependent on state pensions:
£42.24 per week

Gardening
We do not allow for gardening costs.

Transport and travel
Mobility cost should be met by benefits such as DLA Mobility component, and travel concessions. Only costs that exceed this allowance will be considered. The need for specialist transport should be evidenced in your care plan.

Communication needs
This will be a discretionary allowance based on evidence that costs exceed everyday living expenses, and are disability related. Examples of the type of cost we will allow are BSL interpreters. The cost of a telephone, or internet access is regarded as an everyday living expense and allowance will not be made unless it can be proved that additional costs have been incurred as a result of your disability.

Disability related equipment
No allowance will be made for disability related equipment if it has already been provided free of charge by the Community Equipment Loan Service, or the purchase has been supported by grant funding. This includes the purchase, maintenance and repair of such equipment.

If you have purchased an item of equipment privately we will only allow for this expenditure if we consider that it helps you to live independently or enter employment and has been endorsed by the council's occupational therapy service. We will not allow expenditure that we consider to be a lifestyle choice. We will consult your care plan to identify your needs.

Examples of items of equipment that are covered by this section include:
• Wheelchairs
• Powered beds
• Turning beds
• Powered reclining and lifting chairs
• Stairlifts
• Hoists

If you wish to claim an allowance for expenditure in relation to the above items we will consider your request based on the criteria already outlined. All claims should be supported by evidence of purchase.

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Miscellaneous
You may have other disability related expenses that you think should be included. Please consider this and list the items. They will be considered, and an allowance will be made if it is deemed appropriate.

Note
All requests that are not covered above, or are subject to our discretion, will be considered by a panel of specialist staff.

Item	Things to consider	Evidence required	Total Cost (£)	Weekly Cost (£)
Fuel and heating	Do you feel the cold and need your temperature to be set higher? Is the heating on at night? Are you housebound and need the heating on all day?	Last 4 bills for all types of fuel		
Community Alarm System	Do you pay a provider privately(other than the council or your landlord) for a Community Alarm System?	Bills from provider		
Privately arranged personal care	Do you pay someone privately to look after your personal needs?	Signed receipts for at least 4 weeks/visits using a proper receipt book		
Laundry	Do you spend extra on washing clothes, or sending things to the dry cleaners due to your disability? Do you do more than 4 loads of washing per week?	See Care Plan to identify incontinence problem		
Clothing	Do you need special clothes or shoes to be made for you?	See Care Plan for reference to abnormal wear and tear		

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	Do you need more clothes due to frequent laundering or wear and tear due to your disability?	on clothing. Show receipts		
Diet and food	Do you need a special diet or certain kinds of food to improve or maintain your health? Please give details	We may seek permission to ask your GP for confirmation of special dietary needs		
Transport and travel		Evidence in Care Plan of need for specialist transport		
Disability related equipment		Evidence of purchase if available. No allowance if provided free of charge		
Communication needs		Evidence of exceptional expenditure		
Miscellaneous	You may have other expenses that have not been covered in this form.	Evidence of exceptional expenditure		
Total				

Please use the space below if you wish to add any other information about your individual circumstances in support of your claim for disability related expenditure.

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Appendix B

Charges for non-residential services

Guide to the appeals procedure

Customers have the right to request a review of their charges if they consider the charge is unfair, or if they believe they cannot afford the charge.

Their case will be put before the relevant Head of Service. It is important that as much information as possible is provided regarding household expenditure, and any other matters that may impact upon the customer's ability to pay. The Head of Service will be advised by the Group Manager and the Financial Assessments Team Leader.

The decision to waive or review a charge is based primarily on income and expenditure, and the relevant Head of Service will make their decision based on all the information and documentation provided.

There are three courses of action available:

• A temporary reduction in charge (maximum period 6 months)

• A temporary non payment (maximum period 6 months)

• The full charge should be upheld

Charges cannot be waived indefinitely and will be reviewed prior to the end date.

The customer, or their representative, will be informed of the decision in writing.

Customers may appeal against the decision. Appeals must be made within 28 days, in writing, addressed to:

Debbie Mitchell
Head of Finance
Housing & Adult Social Services
PO Box 402
George Hudson Street
YORK
YO1 6ZE

Annex 1

Appendix C – Financial assessment form *(currently being updated)*

Annex 1

Appendix D

What you can expect from us when we visit you

- Anyone who visits you at home will have had the appropriate training or induction and will be competent to undertake their particular role.
- We will treat you with courtesy and respect and will ensure that anything confidential will not be divulged without your consent. (Except in cases where it is required by law to do so, would prevent harm to you and/or it is judged to be in the public interest.)
- We will always give details of how to contact the service if you need to.
- Anyone who visits you at home must present you with an up to date photo identity card. Access should be denied to anyone professing to be a Council employee if they do not have a photo identity card to show you.
- We will ask whether you want to be called by your first or last name and we will respect your preference.
- We will listen to you and respect your privacy and dignity at all times.
- Copies of all forms completed during the assessment will be made available for you.

If you are in any way unhappy with the way our visiting staff have treated you please contact the Head of Housing & Adult Social Services Finance.

Annex 1

Appendix E

Charges for non-residential services

Current charges

The following charges will apply with effect from the 2nd April 2007 ;

Customers cannot or will not be charged if one of the following applies ;

If their total income is less than or equal to ;

Basic Income Support level plus 25% or
Guaranteed Pension Credit Level plus 25%

This is currently equivalent to £148.81 per week.

If customers suffer from Creuzfeldt Jacob Disease, they cannot be charged.

If customers are subject to Section 117 of the Mental Health Act 1983 , they cannot be charged.

If a customers care package has been accepted as 100% Health responsibility, the package is fully funded by Health and they will not have to pay these charges within the NHS Continuing Care Criteria.

Scale of Charges

The following scale of charges will apply from the 2nd April 2007

Home care : £15.00 per hour

Day Care : £3.00 per day or session

Transport : £1.70 per day

Laundry : £3.45 per load

Warden Call : £4.00 per week

Meals at Day Centres : £2.35 per meal

Treatment of savings

Customers with capital above £21,000 will be charged at the prevailing hourly rate on their actual hours of service.

Customers with savings over £12,750 but less than £21,000 will have a tariff applied to their savings on the basis of £1 for every £250 above £12,750 and up to £21,000.

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CITY OF YORK COUNCIL

HASS11

Meeting of the Executive Members for Housing and Adult Services and Advisory Panel

15 January 2007

Report of the Director of Housing & Adult Services

Mental Capacity Act 2005: Briefing Paper

Objective

1. The objective of this report is to inform the Executive Member of action that has been taken and is required to implement the Mental Capacity Act 2005

Summary of the Act

2. The Mental Capacity Act 2005 is due to come into force in England and Wales in April 2007 (legislation in Scotland has already been implemented – Adults with Incapacity (Scotland) Act 2000). The Act provides, for the first time, a statutory framework for assessing whether a person has capacity, for acting and making decisions on behalf of individuals who lack capacity and for empowering and protecting vulnerable people who are not able to make their own decisions. It makes it clear who can take decisions, in which situations and how they should go about this. It enables people to plan ahead for a time when they may lose capacity. It addresses the issue of providing care and treatment for people who lack capacity. Its scope is wide-ranging, involving decisions regarding personal welfare and financial affairs.

3. Everyone working with and/or caring for adults who lack capacity, whether they are dealing with everyday matters or life-changing events in the lives of people who lack capacity must comply with the Act. In a day-to-day context, mental capacity includes making decisions or taking actions affecting daily life – when to get up, what to wear and what to eat. In a legal context, it refers to a person's ability to do something, including making a decision, which may have legal consequences for the person lacking capacity, or for other people.

4. The Act is based upon five principles:

   - Assume a person has capacity unless proved otherwise.
   - Do not treat people as incapable of making a decision unless you have tried all you can to help them

- Do not treat someone as incapable of making a decision because their decision may seem unwise

- Do things or, take decisions for people without capacity in their best interests

- Before doing something to someone or making a decision on their behalf, consider whether you could achieve the outcome in a less restrictive way

5. Guidance on the Act is provided in a Code of Practice. The draft Code was circulated for consultation in the summer of 2006. The final version is to be published late December 2006 / early January 2007. The Act is outlined in more detail in Annex 1

6. Every local authority in England and Wales will be affected by the Act as they provide a range of services involving both personal welfare (social care) and financial management for people with reduced capacity, including people with:
   - Learning Disability
   - Dementia
   - Mental Health
   - Fluctuating Capacity
   - Acquired Brain Damage
   - Those whose have communication problems & required testing of capacity

7. Implementation of the Mental Capacity Act

The Local Authority is responsible for establishing a Mental capacity Act Local Implementation Network within its area. The objective of this network is to support the three key areas of activity are required to implement the Act:

7.1. Review of policies & procedures

- All social care, housing & financial policies & procedures must be reviewed against the principles in the Act. Local Authorities need to request that Independent Sector care homes and hospitals and primary & secondary health care organisations use the toolkit supplied to assess their readiness to implement the Act.
- Staff in some authorities may already be receivers for clients under the Mental Health Act 1983 with power to control financial affairs. Receivers will be called deputies under the new Act and each local authority will need to consider whether it wishes to expand its role to manage personal welfare decisions as allowed for by the Mental Capacity Act.
- Staff involved in vulnerable adult procedures will need to take account of the Act, which should help make swifter decisions for people lacking capacity, especially with regard to moving accommodation.

7.2 Education & training: identify key staff to assess capacity

- Staff training and awareness raising across all the relevant organisations will be a key feature in the run up to the Act's implementation. City of York Council will receive a grant of £12, 000 in 07/08 (estimated) plus start up costs for 06/07.
- Government funding will be made available for Local Authorities for training on a local multi agency level. It has not been confirmed if this is an annual rolling allocation, but needs to focus upon the Act.
- Education & training falls into 2 main categories:
    - General Awareness: it is proposed to cascade training methods targeting first line managers across a range of public, care, healthcare & corporate settings
    - Assessment of Capacity: all identified staff who will be required to carry out assessments
- The delay in issuing the final code of practice will cause the delay of finalised training materials being issued, as they are linked to the Code.

7.3 Commissioning an Independent Mental Capacity Advocacy service

The Local Authority is responsible for commissioning an Independent Mental Capacity Advocate service (IMCA). The IMCA has a clear role in supporting a person lacking capacity who has no-one else to act on their behalf. The IMCA has legal authority to examine records (NHS, local authority, care home etc), obtain second medical opinions for treatment decisions, amongst a range of powers.

The IMCA service for York is to be funded from a £18,975 grant. A late growth bid to the Government can be submitted if this amount proves to be insufficient for the anticipated level of service and required calibre/skills base of IMCAs.

8. Action Plan

The action required to implement the Act breaks down to two phases:

Immediate Action (this has already started)

- A Mental Capacity Act lead officer and Training and Commissioning lead officers have been identified within the Council.
- The multi-agency Local Implementation Network had its first meeting on18 December 2006. This will agree an Action Plan, sign off the Training Plan (when training materials & guidelines are produced by the DoH) & oversee the commissioning of the Independent Mental Capacity Advocacy Service required by the Act.
- An estimate is being put together for:
    - the number of people who may be ' unbefriended & lacking capacity ' in a range of settings.
    - the numbers of staff who require training at both levels
- Commissioning the IMCA service. It has been agreed with North Yorkshire Council that this service should be commissioned on a North

Yorkshire and York basis to cover the geographical area of both authority's and the new Primary Care Trust.
- A review policies & procedures with special reference to operational practice will be undertaken.

Medium term Action

- To agree across all agencies a rolling programme of training: to cover the Primary Care Trust, Independent & voluntary sector training and CYC staff. Designated staff will need to receive training on assessment of capacity.
- To ensure the information and new data systems being implemented in the Directorate take account of the implications of the Act

9. Implications

9.1 Financial

The financial implications of this Act relate to the implications of developing the infrastructure required. The key components of this are

- the commissioning of the IMCA service for which there is the specific grant of £6,306 for 2006/07 and £18,975 for 2007/08

- staff training for which there is a specific grant of £12,626 in both 2006/07 and 2007/08.

9.2 Human Resources (HR)

There may be implications for job descriptions for staff taking additional responsibilities. The implications are currently being examined and will be reported if necessary at a later stage..

9.3 Equalities

This Act will enhance equality for vulnerable adults as it assumes capacity but recognises the need for specific support with decision making that is not currently available.

9.4 Legal

This is legislation from Central Government and Local Authorities are required to implement the Act from 1 April 2007. The Authority has legal representation on the Implementation Group.

9.5 Crime and Disorder

There is a new criminal offence within the Act of ill treatment or neglect of a person who lacks capacity. However, there are no immediate implications anticipated other than a review of the adult abuse procedures may be required.

9.6 Information Technology (IT)

There are no immediate implications but data bases will need to be adapted to reflect the implementation of the Act in individual circumstances.

9.7 Property

There are no property implications.

9.8 Other

There are no other implications.

10 Risk Management

The risk of not implementing the Act appropriately will be from legal/human rights challenges as the Act becomes live. This risk will be managed through the multi-agency Implementation Group and the training that will be provided for staff.
The risk of insufficient or unavailable advocacy services is to be managed through jointly commissioning the service with North Yorkshire Council utilising the funding available to both authority's.

11 Recommendations

That the Advisory Panel advise the Executive Member notes the contents of this report.

Reason: The Mental Capacity Act 2005 will be implemented on 1 April 2007 and Local Authorities are required to make the appropriate arrangements for systems to be in place by this time.

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Wards Affected: *List wards or tick box to indicate all* **All** ✓

For further information please contact the author of the report

Background Papers:

Mental Capacity Act 2005

Annex:

Annex 1 - Summary of Mental Capacity Act 2005

Annex 1 Summary of Mental Capacity Act 2005

Who is affected?

1. The Act applies to all persons habitually resident or present in England and Wales and is likely to have the greatest impact on the following groups:

- 700,000 people in UK with Dementia, projected to rise to 840,000 by 2010
- 145,000 adults with severe & profound learning disabilities in England
- 120,000 people in the UK suffering long term effects of severe head injury
- Mental Illness: at some point in their lives:
  1% subject to schizophrenia
  1%subject to manic depression
  5% clinical depression

It applies to all adults aged 16 years and above (with one exception in relation to children under 16 who lack capacity and will continue to lack capacity in relation to their property and financial affairs when they reach 18 years. This may be referred to the Court of Protection to make a decision before the age of 16 years).

2. The Act is underpinned by a set of five key principles:

- **A presumption of capacity** – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise;
- **The right for individuals to be supported to make their own decisions** - people must be given all appropriate help before anyone concludes that they cannot make their own decisions;
- That individuals must retain the **right to make what might be seen as eccentric or unwise decisions;**
- **Best interests** - anything done for or on behalf of people without capacity must be in their best interests;
- Least restrictive intervention – anything done for or on behalf of people without capacity should be the **least restrictive of their basic rights and freedoms**

Two-Fold test: someone lacks capacity if they are unable to make a *particular decision* because of an *impairment of, or a disturbance* in the functioning of, the mind or the brain

What does the Act do?

3. The Act enshrines in statute, current best practice and common law principles concerning people who lack mental capacity and those who take decisions on their behalf. It replaces current statutory schemes for enduring power of attorney and Court of Protection receivers with reformed and updated schemes.

The Act deals with the assessment of a person's capacity and acts by carers of those who lack capacity

- **Assessing lack of capacity** – The Act sets out a single clear test for assessing whether a person lacks capacity to take a particular decision at a particular time. It is a 'decision-specific' test. No one can be labelled ' incapable' as a result of a particular medical decision or diagnosis. A lack of capacity cannot be established merely by reference to a person's age, appearance, or any condition or aspect of a person's behaviour, which might lead others to make unjustified assumptions about capacity.
- **The fundamentals of the capacity test – the inability to make decisions due to:**
    - Unable to *understand* the information relevant to the decision
    - Unable to *retain* the information
    - Unable to *use* or *weigh* that information as part of the process of making the decision, or
    - Unable to *communicate* the decision
- **Best interests** – Everything that is done for or on behalf of a person who lacks capacity must be in that person's best interests. The Act provides a checklist of factors that decision-makers must work through in deciding what is in a person's best interests. A person can put his/hers wishes and feelings into a written statement of they so wish, which the person making the determination must consider. Also, carers and family gain a right to be consulted.
- **The fundamentals** of **best interests –** Consider all relevant circumstances including:
    - Possibility of future capacity
    - Permit participation or encourage improvement in ability to participate of person concerned in decision making about them
    - Take into account past and present feelings, beliefs and values likely to influence decision if had capacity
    - Take into account and if practicable consult with a range of identified persons
    - Consider any relevant statement made when the person had capacity
    - Not be motivated by a desire to bring about the person's death when the decision relates to life-sustaining treatment
- **Acts in connection with care or treatment** – Where a person is providing care or treatment for someone who lacks capacity, and then the person can provide the care *without incurring legal liability*. The key will be proper assessment of capacity and best interests. This will cover actions that would otherwise result in a civil wrong or crime if someone has to interfere with the person's body or property in the ordinary course of caring. For example, by giving an injection or by using the person's money to buy items for them.
- **Restraint/deprivation of liberty**. The Act defines restraint as the use or threat of force where an incapacitated person resists and any restriction of liberty or movement whether or not the person resists. Restraint is only permitted if the person using it reasonably believes it is necessary to prevent harm to the incapacitated person and if the restraint used is proportionate to the likelihood and seriousness of the harm.
- However, restraint does **NOT** permit any act that *deprives* a person of *their liberty* within the meaning of Article 5(1) of the European Convention on Human Rights.
- The Department of Health and National Assembly for Wales have each issued interim advice to the NHS and local authorities on the implications of

the European Court of Human Rights judgement in HL v United Kingdom (the ' Bournewood ' case), pending the development of proposals for new procedural safeguards for the protection of those people falling within the ' Bournewood gap'. It is envisaged that a protective framework will be introduced within the impending new Mental Health Bill.

4. The Act creates two new public bodies to support the statutory framework, both of which will be designed around the needs of those who lack capacity

- **A new Court of Protection** – The new Court replaces the previous Court of Protection and will have jurisdiction relating to the whole Act and will be the final arbiter for capacity matters. It will have its own procedures and nominated judges. In addition to dealing with decisions relating to property and finance as before, it will now also cover personal welfare (care and treatment) decisions, previously made in the High Court. The Court will make decisions in disputed or complex circumstances regarding:
    a. whether a person has capacity or lacks capacity to make a specific decision or series of decisions
    b. the lawfulness of acts done or proposed in relation to that person, including the failure to act
    c. the validity of any lasting power of attorney or advance decision
    d. the Court can appoint a deputy to make decisions regarding personal welfare and financial matters in relation to a person lacking capacity

  Personal welfare decisions could include: where a person should live, prohibit contact with a named person and give or refuse consent to treatment etc. Financial decisions could include: control and management of property, execution of a will, discharge of debts and sale/acquisition of property. Neither of these lists is exhaustive.

- **A new Public Guardian** – The Public Guardian (PG) and his/her staff will be the registering authority for Lasting Powers of Attorney and deputies. They will supervise deputies appointed by the Court and provide information to help the Court make decisions. They will also work together with other agencies, such as the police and social services to respond to any concerns raised about the way in which an attorney or deputy is operating. A Public Guardian Board will be appointed to scrutinise and review the way in which the PG discharges his/her functions. The PG will be required to produce an Annual Report about the discharge of his/her functions.

5. The Act deals with two situations where a designated decision-maker can act on behalf of someone who lacks capacity:

- **Lasting Powers of Attorney (LPAs)**- The Act allows a person to appoint an attorney to act on their behalf if they should lose capacity in the future. This replaces the current Enduring Power of Attorney (EPA), and the Act also allows people to let an attorney make health and welfare decisions.
- **Court Appointed Deputies** – The Act provides for a system of court appointed deputies to replace the current system of receivership and receivers in the Court of Protection. Deputies will be able to take decisions on

welfare, healthcare and financial matters as authorised by the Court but will not be able to refuse consent to life-sustaining treatment. They will only be appointed if the Court cannot make a one-off decision to resolve the issues.

6. The Act also includes three further key provisions to protect vulnerable people:

- **Independent Mental Capacity Advocate (IMCA).** An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for him or her – and is therefore ' unbefriended '. They need to be instructed by a decision maker to represent the person – they make representations about the person's wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary, including in extremis going to the Court of Protection. National minimum standards and regulations are to be circulated by the Department of Health (DoH), which has sent some initial guidance to local authorities in respect of commissioning the IMCA service at a local level by local authorities and health trusts. Some authorities may commission existing providers of advocacy services. Central Government has allocated £18,975 to City of York Council for the commissioning of an IMCA service.
  The Local Authority is responsible for commissioning & implementing the establishment of an Independent Mental capacity Advocate service.
  The IMCA has a clear role in supporting a person lacking capacity and legal authority to examine records (NHS, local authority, care home etc), obtain second medical opinions for treatment decisions, amongst a range of powers.

- The Local Authority is responsible for commissioning & implementing the IMCA service. The government grant for York is £18975 and is to provide a service covering City of York Council boundaries. This Authority will jointly commission this generic service with North Yorkshire County Council, given its 24/7 remit
- The regulations (MCA) requires advocates to have both advocacy & IMCA training.
    - A wide range of staff will be required to assess people for capacity from home care/care assistants to care managers etc etc
    - Independent Mental Capacity Advocacy (IMCA) services will be locally commissioned by local authorities with PCT partners and must be in place by 1 April 2007
    - The Government has estimated that the demand for IMCA services in each LA area per week will be 1.5 x care home decisions, 1 x serious medical treatment review plus care review & adult abuse situations. The York IMCA will need to provide a service for patients & residents within the 3 local independent hospitals and for residents in nursing & residential care homes, including those people who do not originate from York.
    - A legal duty is placed upon social services to refer cases to the new Independent Mental Capacity Advocacy service in certain situations: this will include for example those people who have no relative to speak for them: the unbefriended lacking capacity see p5 IMCA

- Local authorities and NHS bodies are placed under a **legal duty** to **instruct an IMCA** under certain circumstances, where the person concerned has been assessed as lacking capacity. These include:

- A local authority proposing to **provide** or to **change** a person's **residential accommodation for more than 8 weeks continuously** (under specifically named legislation: Section 21 or 29 National Assistance Act 1948 or section 117 of the Mental Health Act 1983 and as a result of the local authority acting under Section 47 of the NHS & Community Care Act 1990. Obligations imposed by the Mental Health Act to provide accommodation is excluded) AND the person has no relative, friend, nominated individual, LPA etc who is appropriate to consult in determining the person's best interest.

- NHS bodies are under the same duty in respect of proposing **serious medical treatment** or to proposing to provide **accommodation in hospital for more than 28 days or in a care home for more than 8 weeks etc.** (There are some exceptions listed in the Act)

- The role of the IMCA has been recently extended to include attending reviews of unbefriended and incapacitated people who have been in **a care home or hospital for longer than 12 weeks.**
- . **Advance Decisions to refuse treatment –** Statutory rules with clear safeguards confirm that people may make a decision in advance to refuse treatment if they should lose capacity in the future. It is made clear in the Act that an advance decision will have no application to any treatment that a doctor considers necessary to sustain life unless strict formalities have been complied with. These formalities are that the decision must be in writing, signed and witnessed. In addition, there must be an expressed statement that the decision stands ' even if life is at risk '.
- **New Criminal Offence** – The Act introduces a new criminal offence of ill treatment or neglect of a person who lacks capacity. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

7. The Act also sets out clear parameters for research

- Research involving, or in relation to, a person lacking capacity may be lawfully carried out if an ' appropriate body ' (normally a Research Ethics Committee) agrees that the research is safe, relates to the person's condition and cannot be done as effectively using people who have mental capacity The research must produce a benefit to the person that outweighs any risk or burden. Alternatively, if it is to derive new scientific knowledge it must be of minimal risk to the person and be carried out with minimal intrusion or interference with their rights
- Carers or nominated third parties must be consulted and agree that the person would want to join an approved research project. If the person shows any signs of resistance or indicates in any way that he or she does not wish to take part, the person must be withdrawn from the project immediately. Transitional regulations will cover research started before the Act where the person originally had capacity to consent but later lost capacity before the end of the project.

Code of Practice

8. Whilst the Act sets out the legal framework, the Code of Practice provides guidance and information for those acting under its terms and applying its provisions on a daily basis. It incorporates good practice around the situations that can arise when caring or working with those who lack capacity, including family members, professionals and carers. It describes their responsibilities and focuses on those who will have a legal duty of care to a person lacking capacity and explains how the legal rules set out in legislation will work in practice.

The following categories of people are under a **duty** to have regard to the Code:

- People working in a professional capacity e.g.: doctor or social worker
- People who are receiving payment for work in acting in relation to the person without capacity e.g.: care assistant working in a residential care home for people with learning disabilities
- Anyone who has Lasting Power of Attorney
- Deputy appointed by the Court of Protection
- Independent Mental Health Advocate
- Anyone carrying out approved research

The draft Code is available on the DCA website at http://www.dca.gov.uk/menincap/legis.htm (under ' Mental Capacity Bill and supporting documents '). *It should be noted that the Code is **180** pages*.

9. Interaction with Other Legislation

- **Children Act 1989**

The Mental Capacity Act and the Children Act have an overlap for the 16 – 18 age range and the Court will decide which is the most appropriate Act to use. The Mental Capacity Act is particularly appropriate in cases where there is an expectation that capacity in an individual will not be regained or attained on reaching 18 years of age and The Lord Chancellor has the power to transfer the proceedings to the most appropriate court.

- **Mental Health Act 1983**

An individual may be affected by both the Mental Capacity Act 2005 and the Mental Health Act 1983 simultaneously in some circumstances. This will more likely affect those people with dementia or severe learning disability who are detained in hospital under the Mental Health Act. If decisions about someone's medical care or treatment (not treatment for mental disorder) and the person is assessed as lacking capacity under the Mental Capacity Act (MCA), then the MCA could be applied to them to make a best interests decision. However, the Mental Health Act will override the MCA on decisions concerning treatment for mental disorder.

- **Enduring Powers of Attorney Act 1985**

This Act will be repealed and *lasting powers of attorney* will replace *enduring* powers of attorney. Any enduring powers of attorney made under the 1985 Act will continue to have effect.

- **New Mental Health Bill**

It is anticipated that a clause will be included regarding the Bournewood case (see p3 restraint), which will provide a protective framework and in effect, act as an amendment to the Mental Capacity Act 2005

10 Limitations of the ACT

The Act does **not** allow decisions to be made for a person lacking capacity in any of the following areas:

- Consent to marriage or civil partnership
- Consent to sexual relations
- Consent to divorce or dissolution of marriage or civil partnership (following 2 years separation)
- Consent under the Human Fertilisation & Embryology Act 1990
- Consent to a child being placed for adoption or consent to making an adoption order
- Discharge of parental responsibilities in areas not connected to a child's property
- The Act does **not** allow another person to vote on behalf of someone who lacks capacity

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