Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Progress Report on Outcomes for Frail Older People
Meeting Date:	November 8, 2012
Responsible Officer(s)	Julie Ogley, Director of Adult Social Care, Health and Housing, John Rooke, Chief Operating Officer, BCCG Muriel Scott, Director of Public Health
Presented by:	Julie Ogley

Action Required: The Board is asked to consider the content of this paper.

Executive Summary	
1.	The Health and Wellbeing Board identified Improving Outcomes for Frail Older People as one of its priorities and has set a vision that will ensure that care and support for frail older people is person-centred, safe, cost and clinically effective. This paper outlines the work already in place, progress since the last report to Board in January 2012. It also sets out some key actions required to deliver improved outcomes and response to commitments made in the draft Joint Health and Wellbeing Strategy.

Background	
1.	Frail older people are defined as those aged over 75, often over 85 years of age, with multiple diseases, which may include dementia.
2.	The position of the provision of care, as perceived by Health and Wellbeing Board members at the development session in September 2011, was that standards of care for frail older people with complex conditions needed improvement to deliver better co-ordinated good quality care. The main issues identified are:
	• Disjointed services – between organisations across Central Bedfordshire, both in and out of hours • Services which are commissioned separately and therefore potentially wasting resources • A system which primarily responds reactively with too much emphasis on crisis management

	• A limited evidence base for effectiveness to use when re-designing services • Too many people losing their independence • Lack of information for service users and carers • Good intentions from all partners • Low expectations of care
3.	The draft Joint Commissioning Strategy for Older People in Central Bedfordshire identified the following priorities for action, which also form some of the key commitments in the draft Health and Wellbeing Strategy:
	• **Promoting health** - increase uptake of established screening and prevention programmes using a targeted approach and commission self help and self management programmes • **Early intervention and prevention** - commission an expansion of the multi-disciplinary complex care team across Central Bedfordshire to deliver a case management service to reduce reliance on hospital admission. • **Community Based Support** - commission alternative models of day services, increase the number of intensive home care packages and use of personal budgets, and improve access to telecare and telehealth. • **Improving Quality of Care** - commission services that expedite a timely discharge from hospital and provide rehabilitation or crisis avoidance services at home. Commission an expansive range of integrated services which enable more people to live at home and reduce unnecessary hospital admissions • **Information and Advice** - commission a comprehensive information, support and advocacy and brokerage services • **Mental Health** - commission improved and integrated dementia services and improve access to psychological services for older people • **Social Isolation** - commission additional Village Care schemes • **Housing and Accommodation** – make best use of existing extra care housing options and commission extra if required, strengthen the outcomes from floating support services, provide affordable warmth and strengthen the lettings approach by the provision of signposting and information.
	Actions taken in 2012/13
4.	A rigorous programme of change is underway across health and social care to better support older people in Central Bedfordshire and includes a range of initiatives, strategies and commissioned services.

	Promoting Health
5.	• Continued work to increase the uptake of flu vaccination in the over 65 years population. Although uptake was over 72% in CBC last year, this remained below the England rate and is an important preventative measure. • Commenced implementation of Making Every Contact Counts, to ensure that both health and social care staff deliver relevant brief intervention and advice to older people. • Commissioned Community Alcohol Workers to provide support to people in community settings whose drinking is harmful to their health. • Piloted falls awareness training within Care Homes in Chiltern Vale • Healthy Homes, Healthy People (in conjunction with adult social care, and housing) successful bid to increase uptake of warm front grants and access to home improvements.
	Early Intervention and Prevention
6.	A targeted prevention or "Case Management" model of care in Dunstable is being implemented. Community Matrons and experienced Social workers attached to GP practices in the Chiltern Vale area work with patients including frail older people who are identified as being at high risk of unplanned admissions to acute care or long term social care.
7.	The effectiveness of this Case Management approach will be evaluated to inform further plans on how to best offer case management to other locality areas. Plans to develop a similar approach are planned in Ivel Valley with "in principle" support from several GP practices.
8.	Further work looking at information sharing between health and social care and how to identify people at risk of hospitalisation in a consistent and effective way is ongoing.
9.	A joint Approach to Prevention is being developed with the vision that "Prevention is never too early and never too late". As well as emphasising the promotion of independence and wellbeing, this joined up approach across the whole system will also focus on using resources across the whole system more effectively and efficiently to increase the proportion of investment in prevention and early intervention.

	Community Based Support
10.	The Council's in-house reablement service has been strengthened to provide wider coverage and will be further developed during 2013 to provide an urgent response and falls service to avoid hospital admissions. The reablement team works to reduce the need for ongoing care and some 50 % of people going through the team have no need of further care.
11.	Permanent admissions to residential and nursing care homes for older people were reduced from 724 per 100,000 population in 2010/11 to 696 in 2011/12.
12.	The Council's Overview and Scrutiny Committee has set up a task and finish group to review discharge from hospitals into Central Bedfordshire.
13.	There is an increasing trend in the overall numbers of people receiving self directed support, with greater numbers of older people with personal budgets being supported through an in-house team of Support Planners to help navigate through the process. Training on Support Planning and Brokerage approaches is being provided to a range of Voluntary and Community Providers.
14.	A range of training and awareness raising events being delivered using a brokerage project grant facility to promote self directed support and choice and control. These include events on personalisation and direct payments focussed on older people; ROAR 'Connect All' a project encouraging older people to use the internet; Carer's in Beds - training for carers on personalisation; confident carers course includes focus on personalisation/personal budgets; updating Village Care Scheme volunteers on personalisation/personal budgets.
	Improving Quality of Care
15.	A pilot testing the clinical and cost effectiveness of the Sub-Acute pathways in the Dunstable area is underway. This pilot looks to prevent unnecessary hospital admission through a robust pathway redirecting patients out of hospital and into a short stay medical unit or services such as the rapid intervention team and rehabilitation and enablement services provided in patient's own homes. The entire pathway is clinically led by a Consultant Geriatrician working alongside nurses, therapists and pharmacists. Importantly, social workers play a key role in this system and allow health and social care to come together to better plan out of hospital care for this group of patients. This 12-month pilot is now undergoing an interim evaluation which will review performance and activity, quality, patient experience and outcomes for patients. This joint evaluation with health and social care will be considered alongside the Greenacres pilot, which is also testing the effectiveness of step up and step down intermediate care beds.

16.	A whole systems community bed review across health and social care is currently underway. One of its aims is to map future configuration of services in the community setting and to offer a clearer approach to jointly commissioning community beds and to recommend a revised joined up pathway of care across the area.
17.	An urgent response service to people who fall in their home has been commissioned. This is being delivered in collaboration with East of England Ambulance Service NHS Trust (EEAST) to respond alongside paramedics to people who have suffered a fall but do not require hospital treatment. This service will prevent avoidable trips to hospital by providing the necessary equipment and home adaptations required to keep people living safely and independently in their own home. The service is due to commence in January 2013.
18..	Significant improvements are being made to safeguarding interagency approaches.
	Information and Advice
19.	Focused work is being undertaken to ensure access to timely information and advice, this includes access to information for advocacy and brokerage services. A project looking at the information requirements and support to people who fund their own care has started.
20.	In 2011/12 more people (74%) who use services and carers found it easy to find information about support, compared to 47% in 201/11.
	Mental Health
21.	An integrated early diagnosis and post diagnosis dementia support care pathway will be implemented during 2013 – 2014. This will increase the number of people with dementia receiving a formal early diagnosis and will also enable access to care, support and advice on personalised terms to suit individual needs. Psychological therapies are available to all adults and older people including carers of people with dementia across Central Bedfordshire.
22.	To ensure people can live well with dementia, Central Bedfordshire Council's Medium Term Plan sets out an ambition that 60% of Council commissioned dementia care should be of 'good' or 'excellent' by 2014. This will include improved community support and better awareness and understanding of dementia. Improved care in general hospitals and intermediate care is also central to improved outcomes and quality of life. It is likely that this target will be revised upwards to ensure more challenges to improve the quality of dementia services locally.

	Social Isolation
23.	During the last 12 months, the 27 Village Care Schemes have completed 7554 tasks for about 400 residents. The 27 schemes have nearly 600 volunteers on their books, an increase of 60 from last year. New schemes have been established in Biggleswade and Dunstable. The scheme in Dunstable is organised as a befriending scheme and in partnership with the Town Council, befrienders are matched to residents.
24.	The Council as part of its Medium Term Plan has a target of achieving 100% ward coverage of Village Care schemes. Working is currently ongoing with partners to deliver new schemes in Shefford and Eaton Bray during 2012 and 2 further schemes in Leighton Buzzard and Sandy during 2013. Community groups are also being given support to develop innovative opportunities for social networking and increasing social capital for people who may be isolated.
25.	In Arlesey, the Council has funded a Village Agent post who has been employed to work with the community to signpost residents to services. The Arlesey Village Agent is also working with residents to explore the possibility of setting up a Time Banking initiative.
	Housing and Accommodation
26.	A needs assessment programme for housing and support is underway to better understand unmet need across client groups and to identify the models of support which will best meet needs and aspirations from within available resources. A programme of individual sheltered scheme reviews is also underway, in which options for the future of the scheme are developed and explored with the tenants. There are also emerging plans recommending outcome based commissioning to improve quality of care and secure value for money with the introduction of framework agreements in care home contracts.
27.	The aim is to increase the range of housing options, including residential and home care options aimed at promoting choice and control and improving overall health outcomes and to modernise current provision of in-house accommodation together with supporting people to live independently and in new community based schemes.
Conclusion and Next Steps	
28.	Central Bedfordshire Council and the Clinical Commissioning Group are working with a range of partners, to deliver high impact changes and deliver better outcomes for frail older people. These include redesigning pathways to improve quality of life e.g. falls, dementia, stroke and continence; rehabilitation and reablement and helping people to manage their care as well as possible to prevent or delay deterioration.

29.	There is a commitment from all partner agencies to address the major challenge of improving quality of care by joint working and the integration of service commissioning and provision. The aim is to achieve more rapid diagnosis and response in care management through better integration and development of seamless pathways of care across acute, community and social care sector.
30.	Some improvements have been made to improve outcomes for frail older people. However further work is still needed to deliver the priorities and commitments set out in the Joint Health and Wellbeing Strategy.
31.	A clearer understanding of the resources available and current performance across health and social care, to provide care and support to older people and those with complex care needs is required
32.	The plan to achieve a convergence of integrated health and social care teams aligned to GP locality areas in order to deliver more integrated health and social assessment and personalised care is ongoing but slow. Practical steps like co-location of staff are being considered.
	Detailed Recommendation
33.	It is recommended that the Health and Wellbeing Board: • Note the work to date in delivering improved outcomes for older people • Commit to increasing the understanding of current investment and performance in services for older people and delivering an integrated response for frail older people • Agree on any additional action that the board would like to take to accelerate the impact on outcomes and to deliver the priorities set out in the Health and Wellbeing Strategy..

Issues	
Strategy Implications	
34.	Improving outcomes for frail older people is one of the priorities within the draft Health and Wellbeing Strategy
35.	There is clear alignment with the BCCG Strategic Commissioning Plan and the areas of focus; care right now (urgent or unscheduled care) and care when it's not that simple (addressing complex care needs)
Governance & Delivery	
36.	Delivery and progress will also be reported to the Urgent Care Programme Board, the QIPP Leadership Board, the joint commissioning group and to HCOP.

Management Responsibility	
37.	Responsibility for the delivery of the outcomes rests with Director for Social Care, Health and Housing and the Chief Operating Officer for the Clinical Commissioning Group. This responsibility may be delegated for day to day operational delivery.
Public Sector Equality Duty (PSED)	
38.	The PSED requires public bodies to consider all individuals when carrying out their day to day work – in shaping policy, in delivering services and in relation to their own employees. It requires public bodies to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity, and foster good relations between in respect of nine protected characteristics; age disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.. The draft JHWS has had an equality impact assessment undertaken and this will inform the final strategy including the priority to improve outcomes for frail older people.
	Are there any risks issues relating Public Sector Equality Duty **No**
	No Yes *Please describe in risk analysis*

Risk Analysis
Briefly analyse the major risks associated with the proposal and explain how these risks will be managed. This information may be presented in the following table.

Identified Risk	**Likelihood**	**Impact**	**Actions to Manage Risk**

Source Documents	**Location (including url where possible)**

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