Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Progress report on Improving Outcomes for Frail Older People.
Meeting Date:	21 March 2013
Responsible Officer(s)	Julie Ogley (Director of Adult Social Care, Health and Housing, CBC)
Presented by:	Dr Diane Gray (Director of Strategy and System Redesign, BCCG)

Action Required: The Board is asked to:

1. To note progress towards delivering improved outcomes for frail older people.

Executive Summary	
1.	Improving Outcomes for Frail Older People is one of the priorities of the Health and Wellbeing Board and its vision for care and support for frail older people which is person-centred, safe, cost and clinically effective. The Joint Health and Wellbeing Strategy sets out some key actions required to deliver improved outcomes. This report outlines progress on improving outcomes since the last report in November 2012 and identifies some key areas for further development work.

Background	
2.	There are an estimated 6,500 frail older people in Central Bedfordshire currently but this is expected to double within the next 20 years. Frail older people are defined as people aged over 75, often over 85 years, with multiple diseases which may include Dementia.
3.	Frailty is associated with a loss of independence and vulnerability which impairs the quality of life and psychological well-being of many older people. This in turn is likely to result in increased need for health and social care support.

4.	Work is being undertaken by the Clinical Commissioning Group, to understand the investment in services for frail older people in Central Bedfordshire.
5.	Improving outcomes for frail older people will allow those residents to maintain or regain their independence whilst ensuring that they do not become socially isolated.
6.	Central Bedfordshire is not co-terminous with a district general hospital. Residents are served by a number of hospitals including the Luton & Dunstable, Bedford, Milton Keynes, Lister, Stoke Manderville hospitals. This presents a challenge in ensuring effective hospital discharge arrangements for the population of Central Bedfordshire, particularly for older people discharged from hospital and living in the community who may have higher levels of dependency and more complex health and social care needs.
7.	The Health and Wellbeing Strategy sets out the following key actions:
	• Promote health by increasing the uptake of established screening and prevention programmes
	• Commission an expansion of the multi-disciplinary complex care team to deliver a case management service to reduce reliance on hospital admission
	• 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
	• Commission comprehensive information, support and advocacy and brokerage services
	• Commission improved and integrated dementia services and improve access to psychological services for older people
	• Ensure that additional Village Care schemes are commissioned
	• Ensure suitable accommodation options are available by improving housing and accommodation support and existing extra care housing options
	• Ensure effective floating support services; provide affordable warmth and the provision of signposting and information
Progress to date	
8.	**Promote health by increasing the uptake of established screening and prevention programmes**
8.1	Early control of established risk factors, e.g. high blood pressure, cholesterol and diabetes, is central to reducing rates of disease and disability.

	Interventions such as seasonal flu vaccination, stopping smoking and avoiding harmful drinking can improve health in old age, as does increasing level of physical activity. Early identification and effective treatments for stroke, fall-related illness, vision, hearing, continence, oral health and foot care problems can reduce long term dependency and reablement and rehabilitation services are essential in helping people recover quickly following a period of illness.
8.2	**Progress to date:**
	• 21,930 people have been invited to attend for a Health Check to assess their risk of cardiovascular disease of which 8,213 attended between April and December 2012. As a direct result 107 people had been identified as having high blood pressure, 28 with diabetes and 743 as being obese. These people were all offered interventions to help reduce their risk of ill health later in life.
	• 1,241 people successfully stopped smoking in Central Bedfordshire between April and December 2012
	• The Community Alcohol Liaison Service is now successfully working in Central Bedfordshire to support people who wish to reduce their alcohol intake to safer levels. The alcohol strategy is being updated and will inform future commissioning decisions regarding alcohol prevention support in the community
	• Continued work to increase the uptake of flu vaccination in the over 65 years population. There has been an increase in uptake of vaccination from 72% in 2011/12 to 73.6%., however this remains below the England rate. Further work is needed to achieve and improve on the 75% target as this remains an important
	• Commenced implementation of Making Every Contact Counts (MECC), to ensure that both health and social care staff deliver relevant brief intervention and advice to older people. Training eligible staff in MECC is being negotiated with NHS providers for contracts 2013/14. Performance targets are to train 80% of eligible staff and onward referrals to stop smoking and weight management services will be monitored. Public Health staff are providing training across health and social care organisations, either directly or using the train the trainer model
	• Warm Homes Healthy People initiative continued following successful Partnership bid in December 2012 to increase awareness and prevent the impact of severe cold weather and winter deaths, during which over 1000 residents received guidance with 150 people receiving direct support. In 2013, over 5000 leaflets and book marks have been distributed and direct contact has been made with over 600 vulnerable adults, providing Hotboxes, blankets and food parcels.

8.3	**Next steps:**
	• Continue to promote the uptake of health checks and increase accessibility e.g. through local workplaces, the travel hub in Dunstable, Pharmacies as well as through GP practices. As from April 2013, for people aged 65-74 years, the health check should also include awareness raising of dementia and signposting to relevant services
	• Work in Local Area Teams and Public Health to engage with early planning for 2013/14 Flu Vaccination programme. Engage with all relevant front-line staff, including social care, to promote the uptake of flu vaccination
	• Continue roll-out of the Making Every Contact Count training to ensure that older people in contact with front line staff are signposted to relevant brief interventions and advice.
9.	**Commission an expansion of the multi-disciplinary complex care team to deliver a case management service to reduce reliance on hospital admission**
9.1	A targeted prevention or "Case Management" model of care is being introduced. This is at implementation stage in Chiltern Vale GP Locality (Dunstable & Houghton Regis area). 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, and interventions are then planned jointly to manage and reduce those risks
9.2	Plans to develop a similar approach are being made in the Ivel Valley GP Locality, with "in principle" support from several GP practices, and the West Mid Beds GP Locality. Each GP Locality area is being approached as a separate project at this stage given the different stakeholder groups in each place.
9.3	The work includes information sharing across professional and organisational boundaries utilising GP practice lists and health condition registers, the use of nationally available "risk stratification" tools, the development of effective interventions to reduce risks to health & independence and the development of effective crisis management plans for individual patients, and joint social work & nursing assessments that draw in other clinical or professional input as appropriate.
9.4	Feedback from the Chiltern Vale area is extremely positive so far and the new social work role directly attached to GP practices appears to have been very well received by health partners as a huge improvement to working relationships. A more formalised evaluation framework is being designed currently.

9.5	The Step up, Step Down service at Greenacres is recording positive outcomes for customers. Of the 80 people who used the service in the first year, 66% were able to return home and 81% were still at home after 6 months.
9.6	A 16 Bed Short Stay Medical Unit (SSMU), led by a Community Geriatrician, has been set up in Houghton Regis and is staffed by a health and social care multidisciplinary team who track patient's progress, plan and implement their care packages. Between April 2012 and January 2013, 437 patients were admitted for up to 7 days for intensive nursing and therapy support. This included 49 patients who were directly admitted by their GP to the unit. The SSMU also successfully navigated 252 patients to community services from Accident & Emergency.
9.7	A joint strategic approach to prevention and early intervention, based on the premise of "**Prevention is never too early and never too late"** has been developed. It sets out a commitment to working together across the whole health and social care economy, including the community and voluntary sector to:
	• Work holistically to promote Health and Well Being and positive lifestyle choices at every opportunity, making every contact count.
	• Encourage individuals to be independent and manage their own health and care, take responsibility for decisions and plan for the future
	• Develop accessible information and advice to support individuals and carers to make informed choices
	• Provide targeted support and information at key life stages and events at the appropriate time to prevent or delay the need for care and support or further deterioration.
	• Use resources across the whole system more effectively and efficiently to maximise investment in prevention and early intervention.
9.8	**Next steps**
	• As part of its commissioning intentions, the CCG will commission a Community Geriatrician (older people's consultant) model to support the primary health care team.
	• Commission community nursing teams to align to GP practices within a 'GP attachment' model. This BCCG-wide model is required to over-arch the distinct projects in each locality. Learning from each initiative will be shared in order to develop a common and consistent approach across Central Bedfordshire, although one which is tailored precisely to local need. This would include developing a delivery plan which would be overseen by the Urgent Care Board.

	• As part of the targeted prevention and case management approach , the Clinical Commissioning Group intends to commission a 'Care Coordinator' model to support patients and carers to navigate the health and social care system
	• Using the learning from Greenacres to develop a service in the North of Central Bedfordshire.
10.	**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**
10.1	Work is commencing in March 2013 to support staff working in the four CBC Older Peoples Day Centres to engage more creatively and effectively within their communities. The emerging joint strategy for dementia will inform how services need to develop for the growing population of residents with complex or intensive needs in the future.
10.2	The development of new Extra Care Housing schemes up to 2016 will create opportunities to develop more inclusive, community hub, day opportunities for residents whose needs are less complex and who do not require specialised facilities for reasons of dignity or safeguarding.
10.3	As a result of the strengthening of the Council's Reablement Service, there is improved outcomes for older people with fewer people needing further care following a period of reablement. 72 clients completed reablement support in January 2013, 50% of which have no need of further care. .
10.4	An urgent urgent response and falls service to avoid hospital admissions pilot has been established. The Urgent Homecare and Falls Response Service (UHFRS) is an extension to the Council's Reablement Service and provide timely, effective support, to adult residents of Central Bedfordshire (particularly older people), following a fall, with the aim of enabling people to remain living independently at home. Urgent Homecare support is provided to customers with social care needs for up to 72 hours, whilst ongoing care arrangements are made.
10.5	The Number of older people permanently admitted to residential and nursing care homes has increased from 677 as at 31st March 2012 to 679 as at 1st March 2013. Residential care decreased from 525 to 506 and Nursing Care increased from 152 to 170. Central Bedfordshire Council was an outlier in terms of the number of people placed in residential care. This has now been mitigated by actions taken to ensure people are not being inappropriately placed in residential care and that community alternatives are being sourced appropriately.

	From a strategic commissioning perspective the people being placed in residential care include a significant number of people with dementia and this, alongside the increase in nursing placements, is in line with commissioning intentions to continue to commission real alternatives to residential care such as extra care and step up/step down care.
10.6	There is an increasing trend in the overall numbers of older 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. The number of older people receiving a Direct Payment is up to 2355 as of January 2013, compared to 1709 at the start of the financial year
10.7	A range of training and awareness activity has also taken place to provide people with more information to promote choice and control through Self Directed Support.
10.8	The Residents of Aragon Roadshow (ROAR) Connect All project is delivering a range of awareness and support sessions on access to the internet for older people in various locations across Central Bedfordshire. Training to its Neighbourhood Care Scheme volunteers, and distributed information about personal budgets in a range of libraries across the area.
10.9	As part of a regional Telecare event, Central Bedfordshire was successful in securing the development of a new Facebook style assistive technology which will enable people to keep in touch with loved ones. The expansion of Telecare is progressing with over 800 customers now using Telecare to enhance their independence.
10.10	**Next Steps**
	• The Older People's Reference Group will be supported to develop its capacity to deliver training on support planning and the group will also provide information on self-directed support at a series of roadshows in various locations across Central Bedfordshire.
	• The on-going review of Direct Payment processes will result in a more streamlined and accessible approach, and a broadening of support options for people using, or being supported to use, direct payments.
11.	**Commission comprehensive information, support and advocacy and brokerage services**
11.1	Access to information and advocacy is improving. Since April 2012, there has been a single provider of advocacy services across health and social care, ensuring a more simplified pathway for service users and carers.

11.2	A new service, PayingforCare, providing information and help with planning, including an online cost planning tool for older people, who fund their own care has been established. This responds to the lack awareness and understanding of the care options available which can result in people who fund their own care going into residential care when other care options may be more appropriate.
11.3	To ensure self funders have access to this service, Council staff have been trained to refer customers to PayingForCare so they can obtain information and advice. This began in January and 12 referrals were made in the first month.
11.4	**Next Steps**
	• An Information Strategy reflecting the wider requirements proposed in the Care and Support Bill is to be developed.
12.	**Commission improved and integrated dementia services and improve access to psychological services for older people**
12.1	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.
12.2	A Business Case has been developed by the CCG in partnership with both CBC and BBC to support the implementation of the pathway, which proposes the setting up of Primary Care located Dementia Liaison Health worker posts and as part of post diagnostic support a dementia navigator service.
12.3	Psychological therapies are available to all adults and older people including carers of people with dementia across Central Bedfordshire.
12.4	Alzheimer's Society have now established a peer support service across Central Bedfordshire and this includes elements of supporting the person and their carer with strategies to enable the person to live better with dementia. These strategies cover: maintaining cognitive functioning, understanding medication, simple aids to memory and understanding legal aspects of advanced planning and power of attorney.
12.5	As part of joint work between BCCG and Central Bedfordshire Council on the Dementia pathway the provision of Signing For The Brain has increased. As of December 2012 there are four weekly groups running which cover each of the CCG locality areas, run by The Alzheimer's Society. The average attendance at each session is 20 people.

12.6	The Council's ambition is for 60% of Council commissioned dementia care should be of 'good' or 'excellent' standard by 2014. To help improve quality in dementia services, the Council has introduced incentive payments and is also undertaking visits to establish baseline information on the current quality of care providers. 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.
13.	**Ensure that additional Village Care schemes are commissioned**
13.1	There is on going concerted efforts through the Ageing Well Programme to reduce social isolation and loneliness.
13.2	The coverage of Village Care Schemes across Central Bedfordshire is currently 93% against a target of 100% by 2014. Currently, there are 589 volunteers with over 1789 tasks carried out for residents between October and December 2012 alone.
13.3	The Village Agent Scheme is being piloted in Arlesey
14.	**Ensure suitable accommodation options are available by improving housing and accommodation support and existing extra care housing options**
14.1	The Council is undertaking a programme of expansion of Extra care housing, across Central Bedfordshire, to provide good quality accommodation in a supportive environment with 24 hour care for those who need it.
14.2	The first of these developments is on the Dukeminster site in Dunstable with easy access to local amenities. This will comprise 80 apartments with a mix of one and two bedrooms. These are designed to enable people live as independently as possible.
14.3	**Community Beds Review**
14.4	A joint review of community beds has been undertaken and a plan for maximising the use of community beds is being discussed. Opportunities so far identified are likely to include:
	• Continuing to commission 29 beds at Biggleswade hospital in 2013/14 • Joint approach to commissioning community beds • Integrated Urgent care pathway • 24 Hours social care falls response service

14.5	The emerging plan will also explore opportunities for:
	• Inclusion of Continuing Health Care beds into the framework agreement for Care Homes • Remodelling Biggleswade Hospital to provide more appropriate short term services for the North of Central Bedfordshire • A Joint Commissioning framework for beds
15.	**Ensure effective floating support services; provide affordable warmth and the provision of signposting and information**
15.1	Work is underway to develop a strategy on the current and future need for an effective approach to Supported Housing. A review is being undertaken in respect of current providers of support services. This will assist in the development of an action plan for the Strategy.
16.	**Conclusion and Next Steps**
16.1	The commitment to delivering improved outcomes for frail older people remains central to the commissioning intentions of the Council and Health services. The focus is partnership working to secure real improvements to ensure a better quality of life experience for frail older people. Key actions include developing innovative approaches as well as 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.
16.2	Some important improvements have been made to improve outcomes for frail older people. However further work is still needed to secure delivery of the priorities and commitments of the Health and Wellbeing Board.
16.3	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.
16.4	A strategic commitment to joint working and maximising resources is required in order to secure real change in the way in which health and social care is both commissioned and delivered. This will also require a clearer understanding of the resources available and a convergence of those resources, where appropriate, to provide care and support to frail older people and those with complex care needs.

17.	**Detailed Recommendation**
	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	
18.	Improving outcomes for frail older people is one of the priorities within the draft Health and Wellbeing Strategy
19.	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	
20.	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	
21.	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)	
22.	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 Joint Health and Wellbeing Strategy has had an equality impact assessment undertaken and informs actions taken to improve outcomes for frail older people. The Clinical Commissioning Group has also published its Equality Delivery Plan.
	Are there any risks issues relating Public Sector Equality Duty **No**
	No Yes *Please describe in risk analysis*

Risk Analysis
There is a risk that some issues and data may get lost as it cross-cuts several themes and priorities within the Health and Wellbeing Strategy. It is recommended that a delivery plan with RAG-rating is produced to give oversight of progress across all outcomes.

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

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