Central Bedfordshire
Shadow Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	Progress report on Promoting Independence, Choice and Control for Adults and Older People .
Meeting Date:	9 May 2013
Responsible Officer(s)	Julie Ogley Director of Social Care, Health and Housing Stuart Rees Assistant Director of Social Care
Presented by:	Julie Ogley Director of Social Care, Health and Housing

Action Required: The Board is asked to:

1. To note progress towards promoting independence, choice and control for adults and older people.

Executive Summary	
1.	Promoting Independence and Choice is one of the priorities of the Health and Wellbeing Board. Supporting people to live independent lives and encouraging greater choice and control is seen as fundamental. It is important that vulnerable people have access to services which are person-centred, promote and sustain independent living. The Joint Health and Wellbeing Strategy sets out some key actions required to deliver improved outcomes. Important progress is being made in promoting independence and choice in adult social care, health and housing. This report sets out current progress on promoting independence, choice and control and identifies some fundamental changes to the way in which services are being designed and commissioned to maximise opportunities for greater independence, choice and control for adults and older people in receipt of care and support.

Background	
2.	The Health and Wellbeing board is committed to delivering improved outcomes for those in receipt of care and support. Fundamental to this is the promotion of independence and choice.

3.	The Council and the Clinical Commissioning Group are committed to helping people to live independently, in their own homes and in their communities for as long as possible and to reduce reliance on the use of institutional care.
4.	There is a commitment to helping all residents, including those who fund their own care, to access high quality care and support as well as ensuring greater choice and control.
5.	Securing high quality care for all in a climate of economic downturn and changing demography requires a fundamental shift in how care is provided. Early loss of independence often leads to increased social care spending. For example, residential care represents £29 million or 34% of net spend on adult social care in Central Bedfordshire. Early use of residential care depletes the resources of those who fund their own care, which then leads to greater demand and pressure on publicly funded support. Proposals on the future funding of adult social care will have significant implications for the council if opportunities for prolonging independence are not maximised. Loss of independence can also mean increased use of acute care services
6.	Promoting independence and choice requires a shift in the ways services are provided.
7.	The Health and Wellbeing Strategy sets out the following key actions:
	• Shift the balance of care from institutional to personal solutions with more effective support for people in their own homes, including widening the use of Telecare, extra care and specialist equipment to promote independence
	• Ensure that people are able to access information and support to help them to manage their care needs enabling them to regain and retain their independence
	• Ensure people are able to manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. Work with Community and Voluntary organisations to enhance the support available locally to people and their carers
	• Continue to support timely discharge from hospital and adopt a whole systems approach to delivering rehabilitation and reablement to promote independence
	• Ensure that Carers receive the care and support they need to enable them to continue in their caring role as well as maintaining their own health and well being

Progress to date	
8.	**Shift the balance of care from institutional to personal solutions with more effective support for people in their own homes, including widening the use of Telecare, extra care and specialist equipment to promote independence**
8.1	The aim is to move services closer to people and reduce dependency and pressure on institutional care. This requires strengthening reablement through more effective coordination of services and investment in community based options to enhance care closer to home.
8.2	The Council has been reducing its usage of general residential placements through the use of reablement services and access to step up/step down in Dunstable (intermediate care beds). These services have enabled people to leave hospital sooner and have prevented admission to care homes as well as assisted some people to leave residential care homes and return home.
8.3	The expansion of reablement and closer working with health services in the community is helping people to maximise their independence, enabling them to remain in or return to live in their own homes.
8.4	In 2011/12 a total of 1,626 customers were supported by the reablement service. Of these only 25 were unable to stay at home. 296 customers were supported following a discharge from hospital. The reduction in care hours achieved as a result of the reablement service was 3,185 in 2011/12, compared to 2,139 in 2010/11. 34% of customers that benefited from the reablement service in 2011/12 required no further care from the Council, compared to 28% in 2010/11
8.5	Reablement is being further extended through an Urgent Homecare and Falls Response Service. The service which has been developed in partnership with the Clinical Commissioning Group became operational in January 2013. It provides timely, effective support to adult residents (particularly older people) with the aim of maintaining them independently at home. Support following a fall might include confidence building, providing guidance and training on the use of equipment (such as a walking frame or bath board), or signposting/referral to appropriate agencies for further support (e.g. physiotherapy, chiropody or assistive technology). Urgent homecare support is provided within 2 hours on a 24/7 basis to customers with social care needs for up to 72 hours, whilst ongoing care arrangements are made.
8.6	The Number of older people permanently admitted to residential care decreased from 525 as at 31st March 2012 to 506 as at 1st March 2013. 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.

8.7	To support this work the Integrated Community Equipment Service was retendered in 2012 and now has additional service provision which includes: Trusted Assessor technicians working for the provider so as to speed up Community assessments for such things as kitchen and bathing aids.
8.8	A system fast tracking provision of simple items of equipment and minor works, which enable independence at home, such as grab rails and stair rails has been introduced. The Disability Assessment Services in the Community provides the equipment following an initial Occupational Therapy assessment.
8.9	The Council has introduced a new framework agreement for Home Care Service Providers. From May 2013,all domiciliary care providers who wish to provide services on behalf of the council will have to bid to join a new supplier framework, with a commitment to delivering high standards of care at a fixed price. The framework will help the council to shape the market so that it can provide a higher quality of care with more flexible and personalised services.
8.10	As part of an Adult Social Care Sector Led Improvement 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. Alongside this, the expansion of Telecare is progressing with over 800 customers now using Telecare to enhance their independence.
8.11	**Next steps:**
	• Central Bedfordshire Council, as part of its medium term plan has began a programme of expansion of extra care homes. 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. The Council is on course to deliver 50 additional extra care units by 2014 and will continue to commission real alternatives to residential care such as extra care and step up/step down care, particularly in the north of Central Bedfordshire.
	• Ensure access to good quality care to prevent unnecessary hospital admission and to support people on discharge from hospital. This would need to be underpinned with support in the community with access to a wide range of community based services. In relation to Stroke patients, Bedfordshire CCG are currently procuring an Early Supported Discharge Team to support patients discharged from Bedford and Luton and Dunstable hospitals. The team will provide intensive rehabilitation at home to mild/moderate stroke patients with the same intensity as inpatient rehabilitation.

	• Commence work 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. The focus will be on commissioning a wider range of day activities which are tailored to the requirements of the individual and based within the wider community rather than traditional forms of building based day care.
9.	**Ensure that people are able to access information and support to help them manage their care needs enabling them to regain and retain their independence**
9.1	Access to information and advocacy is improving. From 1 April there will be a single provider of advocacy services across health and social care, ensuring a more simplified pathway for service users and carers.
9.2	A new service 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 of 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. 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.
9.3	The Council's 'Customer First' programme aims to make innovative use of technology so that residents can access council services 24 hours a day, 7 days a week. The website has been relaunched and a wide range of social care information can be accessed by a variety of entry points, i.e. 'Where you are' postcode search, 'Life Events' and 'Do it online', as well as a category menu and general search facility.
9.4	Customer services will also signpost to other organisations and advice on where to find relevant information, e.g., rating information for care homes. Website information includes details such as "Guidelines on selecting a care home". Information is also available about community events such as "Just Ask" and the "Older People's Festival".
9.5	Social Care has a 'golden number' 0300 300 8303 for telephone enquiries and Customer Service Centre Advisors have received training to enable them deal with all types of enquiries including equipment/adaptations, changes to existing support packages and information for those people who fund their own care, as well as signposting residents to voluntary groups or services which can help people stay independent or provide more specialist information.

9.6	Central Bedfordshire Council delivered a project to promote the development of brokerage support. Brokerage is a term used to describe the types of support that people can use to help them plan and arrange for the care and support they need. This links in to the development of more personalised services in the field of health and social care.
9.7	A Grant facility of £35,000 to stimulate brokerage activity by local community groups and agencies was made available through the Transforming People's Lives Grant. £15,000 of which was used to support a range of training activities for local agencies and groups; and £10,000 to provide publicity materials and to deliver a range of awareness raising events
9.8	Right Track - a Community Interest Company (CIC) run by people with learning disabilities has been established. Right Track supports people with Learning Disabilities to access clear and accurate information around personalisation and other changes in social care.
9.9	In the 2011/12 Adult Social Care survey, 73.7% of customers who took part in the survey said that it was easy to find information and advice, compared to only 47.4% in 2010/11.
9.10	**Next steps**
	• The development of a web based resource directory or customer portal via which customers, workers and agencies could gain access to information about adult social care services and signposting, including Home Care provider information.
	• The production of clear information about the customer pathway provided by the Council's care management process; brokerage activities, and how the functions work; and the roles and responsibilities of the Council's in-house services and external providers.
	• To continue to expand and ensure provision of timely and robust information and advice to all service users including self funders.
	• Work closely with Healthwatch Central Bedfordshire as well as other Voluntary and Community Groups to ensure wider access to information and support.
	• To continue to promote the Ageing Well principles of an asset based approach and widening community capacity through initiatives such as Timebanking.

10.	**Ensure people are able to manage their own support as much as they wish, so that they are in control of what, how and when support is delivered to match their needs. Work with Community and Voluntary organisations to enhance the support available locally to people and their carers.**
10.1	There is an increasingly upwards trend in the overall number of people using self-directed support with greater numbers of people using personal budgets and Direct Payments to manage their care and support needs. Central Bedfordshire has exceeded the national target of 70%. An in-house team of Support Planners is available to support people through the process. Discussions are underway to increase the numbers of people receiving direct payments and to establish a new target.
10.2	A survey has been sent to approximately 400 Central Bedfordshire customers (excluding carers) who use Direct Payments to pay for the care and support services they receive. The survey asks these customers for their views on how the Service is working for them and the results will be used by the council to improve the service offer for customers using Direct Payments. To assist this a further survey will be undertaken to measure the success of the change
10.3	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.
10.4	Work on the review of Direct Payments processes is on-going. This will lead to a broader range of support being available for people using direct payments. Changes to the rates for personal assistants will help to stimulate the availability of this form of support. A framework for developing a range of support options is being considered.
10.5	Supported living schemes for adults with learning disabilities, which enable individuals to move from residential care into their own homes, are being introduced in Central Bedfordshire. The 'My Place' project, in partnership with local housing associations, is opening independent living schemes throughout Central Bedfordshire, one of which is Bensons Court, which comprises 10 flats for 12 people, aged over 55 years. A DVD has been produced about this initiative.
10.6	Work is taking place within the Council on the development of specifications for a web-based information hub which will provide a broader range of information to people who are looking for support, and enable new and existing providers to publicise the services they have on offer. Links have been made with the Voluntary Works Consortium (Transforming Local Infrastructure Project) and their development of a similar model for the voluntary and community sector.

10.7	Work with a range of community and voluntary organisations has led to a better understanding of the ways in which brokerage support can be developed locally. This collaborative approach has enabled us to pilot new ways of working and to develop service specifications for various forms of brokerage support. This has helped to inform some of the work on the review of direct payment processes.
10.8	The Council has provided small grants to support a range of local agencies and groups to deliver various training and awareness-raising activity, which has either already taken place or is currently being delivered, with a focus on informing people about the use of personal budgets and self-directed support. This work includes:
10.9	A number of organisations have been funded to raise awareness for carers, older people, people with learning disability and tenants about the opportunities for personal budgets and direct payments.
	• Carers in Bedfordshire – is delivering training courses on personalisation and personal budgets/updating a carers information booklet to include reference to self-directed support.
	• Bedfordshire Rural Communities Charity – has delivered training on personalisation and personal budgets for Village Care Schemes volunteers, and has distributed information on personalisation via libraries and community events, including the distribution of support planning booklets.
	• Older Peoples Reference Group – will be delivering information and training on personalisation and personal budgets via a series of roadshows and other activities linked to providing older people with guidance on support planning.
	• 'ROAR' tenants group - 'Connect All' project (supported by Aragon Housing) – A group of local people supported to deliver training and support to encourage older people to access the internet and to use the World Wide Web as a source of information.
10.10	The Council is also promoting independence through a number of organisations.
	• Alzheimer's Society has reconfigured the service in Central Bedfordshire and now provides:
	○ Peer support groups across Central Bedfordshire offering practical advice and information to the person with dementia and their cares on how to live well with dementia
	○ Information advice line now extended to cover all of Central Bedfordshire with a one stop telephone number

	○ Singing for the Brain groups now been set up to cover the whole of Central Bedfordshire
	○ Closer working with Carers in Bedfordshire to offer a more seamless level of support for people with dementia and their carers to minimise people falling between the gaps between the two organisations.
10.11	Emphasis is being given to the development of Micro-enterprises. Micro-enterprises are small-scale flexible services that respond to local need, providing opportunities for new and innovative approaches to be developed.
10.12	The Council is working with health colleagues on the implementation of Personal Health Budgets from April 2014 for people in Continuing Health Care situations. An interface requiring further development is the linkage between personal budgets and personal health budgets. This will require further work to set targets for the future.
10.13	An Adult Social Care market position statement has been published. It describes the current and potential demand and supply for adult social care services. It also outlines the model of care Central Bedfordshire wishes to secure for its population. The Council is keen to ensure availability of access to a diverse range of high quality care and support services and is adopting an approach to commissioning services which help to facilitate supply so that the market is fit for purpose and able to respond to future care needs. This is the beginning of the Council's dialogue with its care providers to assist in shaping the market.
10.14	**Next Steps**
	• The 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
	• 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. A range of recommendations emerging from the 5 workstreams on the review of the Council's Direct Payment processes will be implemented. This will include improved rates for Personal Assistants; a structure for a more diverse range of support options for people using direct payments; improved communication on the responsibilities of employing personal assistants; a more streamlined monitoring system; and updated policy and practice guidance.
	• The development of timebanks will continue with groups being supported to set themselves up in local communities.
	• Continue support for the development of micro-enterprise/social enterprise models exploring the potential for new and innovative forms of service delivery.

	• Continue support for development of personal health budgets by sharing the experience and expertise developed in social care around the implementation of personal budgets.
	• To refresh the Adult social Care Market Position Statement to give a clear steer to all care and accommodation providers across all sectors.
11.	**Continue to support timely discharge from hospital and adopt a whole systems approach to delivering rehabilitation and reablement to promote independence**
11.1	The challenge in meeting this objective are the number of hospitals discharging patients into Central Bedfordshire and thus requiring flexible systems that offer a consistent experience.
11.2	The Reablement service aims to maximise a customer's independence by providing a period of assessment of up to 6 weeks which is free of charge. In 2012/13 the service received an additional investment of close to £1m.The service works closely with NHS colleagues to ensure referrals are timely and appropriate. Some customers have a period of reablement following rehabilitation.
11.3	As a result of the strengthening of the Council's Reablement Service, there are 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.
11.4	The Council has commissioned 8 step up /step down beds at Greenacres in Dunstable to provide a period of reablement in a residential setting prior to people moving back home following admission to hospital.
11.5	Short stay medical unit, Houghton Regis (SSMU): This is a sub acute unit, managed by the South Essex Partnership Trust (SEPT), which has 16 beds for the residents of central Bedfordshire. It aims is to prevent customers going into mainstream hospital wards and, if they do, to facilitate their early discharge from these. It has a maximum stay of 7 days. The unit has 3 designated social workers who link closely to the clinical navigation team and Greenacres.
11.6	**Next Steps**
	• There are some key gaps in the emergency and urgent care pathway within Central Bedfordshire, especially within the North area and over 2013/14, the Council and health partners need to plan to ensure that there is a consistent offer across Central Bedfordshire area. It is intended that the community bed review will assist in setting the direction of future provision.

	• The need to have a “Greenacres” type facility in the North of Central Bedfordshire (data from admissions to residential care in 2012/13 infers 30% of these were customers placed from respite care. A reablement facility would reduce this figure significantly)
	• The need for slower track recuperation facilities for patients for whom rehabilitation may not be fully achieved but require time to regain their health and well being outside of a formal hospital setting
12.	**Ensure that Carers receive the care and support they need to enable them to continue in their caring role as well as maintaining their own health and well being**
12.1.	An increasing number of carers are being supported in their caring role and to maintain their own health and wellbeing through advice and information, and a carer’s break.
12.2	In response to need identified in the south of Central Bedfordshire and changes to services offered by the Alzheimer’s Society, carers now have more access to practical, emotional and social support through the establishment of an additional NHS Carers Café in Eaton Bray. This is in addition to the existing NHS Carers Café and NHS Breaks and Training grants administrated by Carers in Bedfordshire as part of the joint NHS and CBC contract for carers support services.
12.3	A variation on the carers support service has been agreed for 2013-14 to ensure that siblings of young carers and people caring for someone with Dementia have access to appropriate support.
12.4	Carers continue to receive advice, information, networking and opportunities to feedback about local services through the quarterly CBC Carers Forum including feedback from NHS colleagues.
12.5	The Adult Learning Disability Team (ALDT) is working with older family carers of adults with a learning disability where support between the carer and the cared for is often inter-dependant. Work is undertaken with them to identify contingencies in the event that one of them becomes less able including the possibility of them both being able to access extra care. Work is also ongoing in supporting older carers and their adult son / daughter / family member to support them in the transition of the cared for person in moving on from the family home.
12.6	Annual Health Checks are also progressing well, especially targeting adult siblings with a learning disability living with older carers. Some GP practices are now sending out a further invitation to remind those who have yet to respond. Most difficult group to reach appear to be those who live on their own or with family; effectively those having little contact with care providers, health or social services.

12.7	The Health Facilitation Service co- located within the ALDT has started to personally visit all practices in Central Bedfordshire, reminding clinicians and patients of the need for Annual Health Checks as well as the support that Health Facilitation can provide. Health Facilitation Service will identify those GP's patients that may have little routine contact with Health and Social Services and seek to encourage and support their attendance. Health Facilitation Service will contact all major service providers in Central Bedfordshire area to emphasis need for health checks and offer support.
12.8	**Next Steps**
	• To monitor the impact and outcomes of the varied contract for 2013-14 including reporting to the Carers Delivery Partnership and feeding into the refresh of the JSNA."
	• Health facilitators continue to support service users to book and attend the Annual Health Checks and where appropriate direct individuals to the NHS Health Check (40 -74 year old) and offering support with these.
13.	**Conclusion and Next Steps**
13.1	Achieving the vision and commitments of the Health and Wellbeing Strategy for promoting independence, choice and control for adults and older people in receipt of care and support in Central Bedfordshire requires a robust partnership framework which will create and oversee the delivery mechanism for this priority. This will require reframing of the Healthier Communities and Older People Partnership and a further report to the Health and Wellbeing Board in this respect.
13.2	There needs to be a more detailed analysis of the key drivers and opportunities within the service re-design and commissioning approaches for promoting independence and embedding greater choice and control across health and social care will be required in the first instance.
13.3	Further work needs to be undertaken to establish a performance framework which will underpin the delivery of this priority.
14.	**Detailed Recommendation**
	It is recommended that the Health and Wellbeing Board:
14.1	Note the work to date in promoting independence and choice
14.2	Approve the reframing of existing partnership arrangements to create a delivery mechanism for this priority which will be reported to the September meeting of the Health and Wellbeing Board.

Issues	
Strategy Implications	
33.	Promoting independence and choice is one of the priorities of Health and Wellbeing Board
34.	Bedfordshire Clinical Commissioning Group's Plan for Patients 2013/14 sets out a commitment to promoting independence and choice through: • Patient choice and the ability for patients to chose the provider of their care, when and where it place and who provides it. • Improving services for older people to support independence and avoid emergency admissions • System redesign, creating primary care-based multidisciplinary teams that interface with specialist care services in order to support carers and maintain patients' independence for as long as is safely possible and ensure a good quality of life and a good quality end of life
Governance & Delivery	
35.	Delivery and progress will also be reported to through the joint commissioning group, HCOP and the Health and Wellbeing Board.

Management Responsibility	
36.	Responsibility for the delivery of the outcomes rests with Director for Social Care, Health and Housing. This responsibility may be delegated for day to day operational delivery.
Public Sector Equality Duty (PSED)	
37.	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 JHWS has had an equality impact assessment undertaken. Equality Impact assessements are an integral part of any service redesign
	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**
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Source Documents	**Location (including url where possible)**