Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No.
Title of Report	**Improving Outcomes for Frail Older People- Steps, Milestones and Delivery Mechanisms**
Meeting Date:	5 September 2013
Responsible Officer(s)	Julie Ogley, Director, Social Care, Health and Housing, Central Bedfordshire Council Diane Gray, Director, Bedfordshire Clinical Commissioning Group
Presented by:	Elizabeth Saunders, Assistant Director, Commissioning

Action Required:	
1.	**To note progress made towards priorities identified by the Health and Wellbeing Board to improve outcomes for frail older people,**
2.	**To note challenges and opportunities that exist, next steps, key milestones and delivery mechanisms.**

Executive Summary	
1.	This report outlines what is currently working well and areas for further focus and development that support the Priority Area. Evidence of improved outcomes and successes being achieved for frail older people are presented. The report also describes next steps, key milestones and delivery mechanisms across work areas. The Board is invited to note the progress made.
Background	
2	In March 2013, the Health and Wellbeing Board requested an update on the improved outcomes being achieved for frail older people with a clear summary of the next steps, key milestones and delivery mechanisms.
3.	The intention of the report is to highlight in an open and transparent appraisal what is working well and impacting positively on improving outcomes for frail older people. The report also highlights what is not working and where the priorities need to be focussed with an outline of key steps for how this would be achieved.

4.	Since the last report to the Board in March, Central Bedfordshire Council (CBC) and Bedfordshire Clincial Commissioning Group (BCCG) have taken co-ordinated and important actions to make a difference to frail older people across Central Bedfordshire. In June key partners reviewed work programmes and services aligned under the priority area, highlighting key successes, challenges and future priorities. This identified the vast amount and diversity of work taking place that contributes to improving outcome for frail older people, however it also identified mixed views on progress and priorities. For example there were differing views on success and progress of work programmes around dementia. Although everybody agreed that this was a priority area, individuals' perceptions varied depending on knowledge and ownership of the workstreams which varied across organisations.
5.	Although much time and effort has gone into reviewing progress of projects and efforts to prioritise work areas for the purpose of this report, it is fair to note that many existing issues related to the difficulties in working across the whole system have remained. For example getting the right people together to make decisions about priority areas, information on the various developments is not centralised and there is limited sharing of information on progress and issues. There is also a range of existing governance arrangements covering the priorities for frail older people which makes coherent and coordinated change more challenging. These include the Healthier Communities and Older People Partnership Board, the Older People Delivery Partnership, the Mental Health Delivery Partnership, the Urgent and Integrated Care Board and the Planned Care Board.
6.	A number of joint strategic initiatives have developed over the last 6 months which have brought together key partners to consider priorities. The recommendations from the Joint Health and Social Care Review (Community Beds Review) give clear priority areas for joint development for services that would improve outcomes for frail older people. Following the July Health and Well Being Board meeting, a delivery plan for implementing the review is currently in development and will be brought to the Board in November.
7.	In June a co-ordinated expression of interest was developed and submitted in a bid to the Department of Health to become a Pioneer in Integrated Health and Social Care. Through the development of the bid and planning for integration, key priorities for future integrated working have emerged.
8.	It is clear that there is a commitment from partners to 'Be bold' in the development of future services and projects with a co-ordinated whole systems approach. However more needs to be done to integrate and achieve this whole system reform. The development and commitment to the Pioneer bid offers an opportunity to accelerate the need for a detailed programme that leads to integration of services, This report contains an analysis of what is really needed to "up the pace" in delivering outcomes for frail older people. The section on "Being Bold" recommends next steps towards reforming arrangements and priorities that will significantly improve the whole system to ensure improved outcomes for frail older people.

Update on Key Successes and Delivery areas	
9.	It should be recognised that there are many initiatives where changes have been implemented in particular parts of the system, and across the whole system, that have demonstrably improved outcomes for frail older people. A full outline of project and services that are delivering results, or being set up to meet a need or system redesign, are outlined in Appendix 1. This outlines existing reporting structure, key next steps and milestones for the projects, and also the difference that is being made to frail older people. A number of key areas of success are identified below, with detail of impact and outcomes.
10.	There is a strong commitment across partners to develop services that **intervene early and prevent** crisis situations or carer breakdowns. Colleagues across the Council and BCCG have developed a joint strategic approach to prevention, developing a joint definition and a toolkit to support colleagues to develop services with prevention at the heart. Support from senior managers has been achieved and plans are in place to expand the approach across wider corporate colleagues. Work is also underway to capture matrix of how to measure the impact of the approach over time in terms of quality of life and cost avoidance. The Ageing Well Board monitors a number of work programmes that are working towards increasing the quality of life of people as they grow old and preventative services are key to this approach.
11.	A key preventative programme that is part of the Ageing Well Programme are the **Village Care Schemes.** These are volunteer run and provide local community support to frail older people aiming to reduce isolation and improve health and wellbeing. These are being set up across Central Bedfordshire and 100% coverage of wards will be achieved by 2014. Schemes in Shefford and Eaton Bray have already opened in 2013 and the final two in Sandy and Leighton Buzzard will be in place by March 2014. Between April to June 2013, there were 2168 individual requests for help (a significant increase on previous quarter), with 473 residents contacting the groups for help. There were 77 new callers with an increase in new 'regulars' such as clients with early stages of dementia who are likely to require help over the longer term.
12.	A **targeted prevention project** has been operating successfully in Chiltern Vale locality, with social workers and community matrons working with local GPs and the hospital to identify vulnerable frail older people. A caseload of around 60 people have been identified with a physical disability or frail older people with two or more long term conditions and regular hospital or GP visits. Individuals have received support from a range of professionals and provided with more appropriate care packages where appropriate. An analysis of the outcomes achieved suggests that for over 40 frail older people a hospital admission or a permanent placement in a care home has been avoided. This service will be extended to cover all Central Bedfordshire locality areas by December 2013.

13.	A **comprehensive reablement service** has developed and is delivering positive outcomes for frail older people, preventing admissions into residential care or needing high levels of home care support. Detailed calculations of the reablement teams capacity and performance indicators have been developed with a clear service specification being finalised. Savings achieved in 2013/14 are predicted to be around £500,000. On average people receive reablement support for 4 weeks and over 50% of people require no further support. This service complements and integrates successfully with rehabilitation and intermediate care services.
14.	The **Urgent Homecare and Falls Response Service** has been working in conjunction with local GPs, the Ambulance Service and BCCG to provide rapid response to people experiencing a fall and in need of support at home. Demand for this service has been considerable and over 100 people per month have received help and avoided a hospital visit. After the initial successful pilot the service is now an embedded service and consideration is being given to expanding this to provide more scope for preventative home care support.
15.	The development of **Community Reablement Beds** at the pilot Step Up, Step Down service in Dunstable (Greenacres) has demonstrated the benefits of care-led intensive reablement. Since opening, the service has supported more than 115 people and over 65% have returned home to live independently. Additionally, of those returning home 75% are still at home after 12 months. An analysis of the financial benefits of this service suggests that net savings of almost £1m per year can be achieved across the health and social care system.
16.	A joint team in the **Short Stay Medical Unit (SSMU)** in Houghton Regis has worked with 398 older people since April 2012. They coordinate support from reablement, occupational therapist and home care teams and to date have helped 293 to return home and live independently or with a care package.
17.	As part of improvements to the **Urgent Care Pathway**, a Social Worker from the hospital team is now working with people attending the Luton & Dunstable Accident and Emergency or the Acute Assessment Unit. Their role is to assess people's needs and, where appropriate, divert them to more appropriate services. Since April this initiative has supported 67 people to take up more appropriate services (72% of those assessed).
18.	As part of a ambitious programme of **increasing accomodation and care options for older people**, a number of Extra Care Sheltered Housing facilities are being planned. The first new Council owned facility in Dunstable, Dukeminster, has been granted planning permission for an 80 extra care sheltered housing unit, with a care home also being developed on the site. The tender for the building development is due to be advertised in August 2013, and the facilities will be open in 2015. Other opportunities for extra care developments across Central Bedfordshire are being appraised and proposals for two further developments are likely to be ready for discussion in the

	Autumn. A grant of £1.7m has been secured from the Homes and Communities Agency (HCA) to support the delivery of the Dukeminster scheme. This will increase the choice and quality of offer for housing with care for older people across Central Bedfordshire.
19.	Agreement has been reached on **joint commissioning arrangements for care home** and nursing care home beds across health and social care. A new contracting arrangement (framework agreement) for care home service has been developed and applications to join the framework were invited in July 2013. Provision has been made for future inclusion of Continuing Health Care beds (CHC) and Reablement beds to be commissioned through these contracts. This will provide efficiencies in commissioning and allow for more customer choice.
What we have learned	
20.	Through the process of reviewing the work areas and priorities a number of lessons were learned which need to be acknowledged and overcome in the future. A key challenge was getting the right people together at the right time, during a changing landscape of staffing and programmes, alongside urgent priority situations, such as the closure of a 77 bed care home. Different parts of the system work to different timescales, leaders and agendas, with a limited joint structure. For example, there is a multiplicity of partnership groups lead by different partners without being based on a shared agenda. It is proposed to review the current governance structure as a result of the changes to the NHS commissioning arrangements, and the development of the Health and Well being Board.
21.	There continue to be challenges around organisational boundaries for both commissioners and providers. These include limited joint commissioning,, information sharing across organisations and focus on service oriented and organisation projects rather than people centred approaches. Work is underway to overcome these barriers, for example current ambitious service redesign programmes across the BCCG are breaking down service boundaries and looking to deliver more co-ordinated people centred services. Opportunities for joint commissioning posts are being considered.
22	Capturing people's experiences and listening to their stories and journeys in a more co-ordinated way needs to happen. Although there are pockets of case studies and capturing outcomes for people, there is not a consistent approach or manner that make these easy to find. To tell whether or not service redesign and developments are successful, it is important to capture how people's experience of care has improved. Currently, proxy measurements are relied on heavily, such as levels of unplanned hospitalisation, emergency readmission to or delayed transfers of care from hospital. There is a need to develop a more robust approach to measuring people's experience. Recent national guidance through the 'Making it Real' publication offer guidance and a foundation for new ways to measure people experience and successes in integrated care and support.

23.	There needs to be further analysis of where the Council and BCCG are investing their budgets and the impact that this is having. There are currently quite 'rough' indicators in place and an improved set of measures that are quantitative and qualitative require development. These will help guide commissioners in terms of programmes and impact across the whole system.
Being Bold – What needs to happen next	
24.	It is clear that, whilst parts of the system are delivering significantly better outcomes for frail older people, more focus on the whole system is needed to deliver integrated, people centred services. In making progress towards greater integration it will be important that new ideas are embraced and that risks are taken in a controlled way. To make a step change towards people centred, integrated services it is inevitable that learning will occur and the experience of others will be important in building lessons learned into practice. This should not restrict the ambition of partners to achieve the vision of integrated care and delivery.
25.	The delivery of an **Integrated Health and Social Care Programme of work** will be essential to improving outcomes for frail older people. A comprehensive picture is developing of what needs to happen to improve outcomes. It is clear that ownership of achieving these aims needs to be wider than just the health and social care system, and other partners have a crucial role to play.
26.	**A number of key areas are emerging** that could significantly contribute towards making a difference to frail older people over the next 5 years. These need further development across partners to co-ordinate programmes of work and detailed delivery plans. Key programmes of work are broadly outlined as: **Early intervention and prevention** **Community and social capital** **Urgent care/Care right now** **Planned care/Care in the future** **Integrated commissioning, governance and performance arrangements**
27.	**1. Early Intervention and Prevention** Preventive services offer a continuum of support ranging from the most intensive tertiary services, such as intermediate care or reablement, through to secondary or 'early intervention' such as risk stratification, through to 'primary prevention' which promote wellbeing and independence. Preventing or delaying the deterioration of wellbeing resulting from ageing, illness or disability is crucial and ultimately delays the need for more costly and intensive services.

28.	The next steps in this area are: • The continued roll our of a **joint strategic approach to prevention**, encouraging senior level sign up across partners and a programme of communication and culture change within organisations. • Continued **investment in preventive programmes** that tackle issues such as social isolation and loneliness.
29.	**2. Community and Social Capital** With the increase in demand for services and reduction in funding across all Health and Social Care and partners, particularly those for frail older people, harnessing the support and enthusiasm of the community will be vital. The key to developing social capital is developing informal and formal networks of support with communities or groups of individuals working together for common purposes.
30.	In Central Bedfordshire this will include areas of work such as: The expansion of high quality small scale local businesses offering non-traditional models of care and support (**microenterprises).** Personalised support will be offered to interested individuals to develop business ideas. The expansion of **timebanks** across Central Bedfordshire with the aim of 8 new schemes by the end of 2016.
31.	**3. 'Urgent Care' or 'Care Right Now'** This is a key work programme that could significantly contribute towards improving outcomes for frail older people. This includes a range of responses that health and care services provide to people who require or who perceive the need for urgent advice, care, treatment or diagnosis. The existing system of urgent care can be confusing and duplicative, resulting in a less than optimal patient experience and inefficient use of resources. Central Bedfordshire faces the additional challenge of having no hospitals within the area and having to co-ordinate various pathways and discharge plans across the six District General Hospitals around Central Bedfordshire.
32.	The next steps will include the following areas of work: • **Joint redesign of an integrated urgent care pathway** to streamline proactive and reactive support arrangement**.** This is crucial to avoid inappropriate admissions to hospital and residential care and support timely discharge, identify and remove gaps and duplications in existing service provision and improve effectiveness, safety, and the experience of patients and people who use services. • Joint approach to **identifying and managing people with both health and social care needs.** This will be essential to support the identification of older people that most need help to prevent a crisis. • Developing **multi disciplinary teams** of health and social care staff to support at appropriate points in the pathways, including navigator roles and health and social care co-ordinators acting as single points of contact.

	• **Increasing availability of rehabilitation beds in the community (Step up step down services).** This is important in reducing the average length of stay in hospital beds, placing greater emphasis on meeting peoples' needs in an appropriate recovery or rehabilitation setting.
33.	**4. Planned Care/ 'Care in the future'** This is a key work programme that could significantly contribute towards improving outcomes for frail older people. This includes support for people with long term conditions, empowering individuals and providing information to make informed decisions.
34.	The next steps in this area will include areas of work such as: A programme of **service redesign** across BCCG commissioned services is being implemented which will radically transform a range of services, including musculoskeletal services, cardiology, ophthalmology, dermatology and stroke services. These aim to provide a more seamless journey with co-ordinated local access to a range of orchestrated care. **Increasing accommodation options for frail older people** through the expansion of Extra Care Housing and stimulating the care home market in the north. This is crucial to ensure choices and appropriate support is available. A **joint approach to commissioning care home services** for health and social care beds will provide greater co-ordination and efficiencies across the system.
35.	**5. Integrated Commissioning, Governance and Performance Arrangements** This will be essential and underpin the delivery of a joint programme of work. Partners need to be ambitious in striving for success in the future and to make the required impact that is needed, working in different ways with a more co-ordinated approach. Priority needs to be given to making this happen with dedicated resources assigned.
36.	A model of future integration needs to be designed together across the whole system, with a suitable governance structure put in place refreshing existing partnership structure for adults and older people. This will ensure that deliverables are jointly managed and co-ordinated, metrics are developed to measure progress across all areas, and the impact and positive outcomes that are being delivered for joint investment is clear.
37.	The approach to developing an effective framework to manage the next steps for key projects can not happen in isolation and a programme approach needs to be adopted. Early discussions are taking place in line with plans to deliver Integrated Health and Social Care as outlined in the Pioneer Expression of Interest. A detailed scoping of commissioning, governance and performance arrangements is needed.

38.	A joint delivery plan should be developed which bring together the BCCGs Plan for Patients, all partners Commissioning Intentions and information from the Social Care, Health and Housing Market Position Statement. With all partners working towards a joint agenda and co-ordinated milestones this means that patients, customers, and providers can be clear about the plans for the future and how outcomes for frail older people will be improved.

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Presented by Elizabeth Saunders