Central Bedfordshire
Health and Wellbeing Board

Contains Confidential or Exempt Information	No
Title of Report	Improving Outcomes for Frail Older People
Meeting Date:	19 October 2016
Responsible Officer(s)	Julie Ogley Director Social Care Health and Housing, Director of Social Care, Health and Housing
Presented by:	Julie Ogley Director Social Care Health and Housing, Director of Social Care, Health and Housing

Recommendation(s) The Health and Wellbeing Board is asked to:

1. **note progress towards delivering improved outcomes for frail older people; and**
2. **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 Joint Health and Wellbeing Strategy.**

Purpose of Report	
1.	This report updates the Board on progress made across a range of initiatives aimed to Improving Outcomes for Frail Older People.

Background	
2.	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.
3.	Following the refreshed strategy in April 2015, two outcomes were identified within this priority: 1. enabling older people to stay well at home for longer 2. helping people with dementia and their carers to feel supported to manage their dementia.

	The key issue to be tackled is to reduce isolation and loneliness in older people.
4.	The Health and Wellbeing Strategy sets out the following key actions: • Ensure that people know where they can go to get help and support. • Promote volunteering and other opportunities to share knowledge, skills and experience e.g. time banking, for people of all ages to promote intergenerational activities. • Use the valuable information from Silver line to enable us to provide support in the areas where it is needed most. • Provide choice in the accommodation available for older people, ensuring that developments promote social inclusion. • Promote local social opportunities outside the home such as health walks, library, leisure and educational activities.
5.	The Health and Wellbeing Board received an update in June 2015. The update outlined the work of the Silver Line, a charity which offers support to older people in the form of a free helpline and telephone support to isolate people using volunteers.

Progress to Date	
	Information, Advice and Support
6.	Central Bedfordshire Council has now commissioned 'Advice Central' to provide social care information and advice to general population residents of Central Bedfordshire. Advice Central assists with delivering advice and information associated to care and support to those who do not want to contact the Council or whose level of need is low (this is more about prevention than dealing with high needs) or who are not sure where to go or who to contact about their enquiry and need an access point to explore their enquiry.
7.	The Just Ask bus delivered by Healthwatch Central Bedfordshire travels throughout Central Bedfordshire to bring information, support and advice from a wide range of partners to local communities.
8.	Silver Line is continuing to offer support to Central Bedfordshire residents, providing befriending and information on local activities. A number of residents also now act as Silver Line telephone volunteers to lonely people outside of CBC.

	Good Neighbour and Village Care Schemes
9.	The Good Neighbour and Village Care Scheme network coordinated by the Bedfordshire Rural Communities Charity provides comprehensive coverage across Central Bedfordshire. The Schemes which are focused around supporting older people continue to expand. There are 36 Schemes, with 925 volunteers. Many of the recipients are isolated older people and many of the volunteers are also older people.
10.	Between April and June 2015, the schemes reported 3464 jobs where people phoned for help. 767 residents contacted the groups and there were 129 new callers in the period.
11.	Transport remains the main issue with which callers required help, making up the majority of total jobs carried out. A total of 2234 journeys were undertaken and most of the journeys were for medical transport.
12.	The Good Neighbour and Village Care Schemes also organise many other social opportunities for local people and also enable people to continue to take part in social activities and everyday tasks such as shopping. Local groups organise a variety of social events such as teas, dances, outings, chair based exercise sessions and regular walks for older people.
13.	The schemes also work with a range of other partner organisations to provide early intervention and preventive services, such as Town Councils, the Fire Service, Public Health, Department of Work and Pensions, and Practice Based Commissioning Groups to deliver falls prevention, crime prevention, benefit take-up, and support in emergency situations such as extreme weather conditions and health issues such as winter flu vaccinations**.**
14.	Some examples of customers outcomes of the VCS/GNS schemes are: **Case study 1:** several groups have reported on how they have given lifts to frail and elderly residents wanting to vote in the referendum. These residents would not have been able to get to the polling stations to express their views without the good neighbour group volunteers. They also appear to have preferred the social outing to vote compared to the idea of registering to obtain a postal vote sent to them at home. **Case Study 2:** A volunteer has added another dimension to her regular Wednesday visit to an older, largely housebound lady. As well as the usual chat over a cup of tea, the volunteer is now reading to the lady (who has macular degeneration and very limited vision) entertaining her with anecdotes from the autobiography of the volunteer's grandfather. He served in India where the lady also lived during her youth so she is very interested in all the detail.

15.	The expansion of the Good Neighbour and Village Care Schemes into more urban areas remains challenging. Consequently, additional funding has been made available and targeted to developing services in Dunstable and the surrounding areas.
16.	The existing scheme in Dunstable was until recently coordinated by the town Council and offered one to one befriending rather than the wider range of services offered by the other schemes. The Bedfordshire Rural Charities Commission is engaging with the communities in Dunstable to relaunch the scheme to offer these wider services.
	Local Social Opportunities Outside the Home
17.	**Day Opportunities for Older People** - A better offer for day opportunities is being developed and is likely to result in closer links with Housing, Libraries and Leisure in order to expand opportunities for people to meet each other where they live and in their neighbourhoods.
18.	**Timebanking** - There are now two operational Timebanks, one in Upper Caldecott and the second in Ampthill and Flitwick. A third scheme in Leighton Buzzard is about to launch.
19.	**Support for Carers** - Support for carers is available through carers cafes, befriending services and now through 2 carers lounges based in Bedford and Luton and Dunstable Hospitals.
20.	**Dementia friends** - As at July 2016, there are now 110 dementia champions and 2132 friends across Central Bedfordshire.
21.	**More people accessing health walks and leisure activities** - Since April 159 older people have participated in Activity 4 Health 50+ sessions. Other activities for older people including: Walking Football, Health Walks, Seated Exercise, Table Tennis, Badminton and Active Life have attracted some 840 attendances since June 2016.
	Independent Living and Extra Care Accommodation
22.	The building of new extra care housing schemes and community hubs will provide further opportunities to create spaces where people can meet and engage in social activities. Two new schemes have opened this year, Priory View in Dunstable and Greenfields in Leighton Buzzard, increasing the number of schemes to 6 and the capacity of extra care by 168 to 301 apartments. The new schemes in particular offer the wider community facilities and places to socialise and meet other people, thus combating loneliness. Many of the new residents have expressed how they now feel less isolated by living within these schemes.

	Measuring Impact
23.	A good measure for determining the effectiveness of these services is through the Adult Social Care Survey. The survey seeks to learn about how effectively services are helping service users to live safely and independently in their own homes, and the impact that these services are having on their quality of life. The result of the 2015/16 survey was published in September.
24.	The results relating to the summary measures suggested above for Central Bedfordshire based on the returns by 365 residents are: In terms of information and advice, some 74.5% said that they found it easy or fairly easy to access advice (nationally 53.5%)(Q12). Adult social care users reporting that they have as much social contact as they would like had decreased to 44.9%, compared to 45.8% when last measured, but 2.9% (5.6% nationally) reported that they felt socially isolated (Q8). 29.1% said they did not leave their home, (26.4% nationally) and an additional 21.5% said they were not able to get out to all the local places they wanted to. (Q18) In terms of depression and anxiety 55.7% (46.8%nationally) said they were not anxious or depressed, 39.1 (45.1%nationally) were moderately anxious /depressed and 5.9% (8.1% nationally) were extremely anxious/depressed. This is a marked improvement on previous figures.(Q14b) 88% of people receiving services said they helped them to feel safe, which is above the CBC target set last year (79%), and above the national average of 85.4%.

Reasons for the Action Proposed	
25.	The Health and Wellbeing Board (HWB) has a statutory duty to promote integration. Improving Outcomes for Frail Older People is one of the priorities of the Joint Health and Wellbeing Strategy.
26.	Improving Outcomes for frail older people is central to the delivery of the Better Care Fund Plan for Central Bedfordshire and also consistent with the strategic direction of the Sustainability and Transformation Plan.
	Conclusion and Next Steps
27.	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. Some of this is evidenced in the report following the Thematic Review undertaken by the Care Quality Commission in Central Bedfordshire in December 2015 (Building bridges, breaking barriers).

28.	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.
29.	There is clear recognition of the need for partnership working across statutory and non-statutory agencies, in order to secure real improvements and better quality of life for frail older people. 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, mental health, social care and the community and voluntary sector.
30.	Work currently underway as part of the Better Care Fund Plan deliverables on Redesigning integrated care pathways for falls, stroke, enhanced care in care homes and multidisciplinary working will contribute towards delivering improved outcomes for people. A separate update on key deliverables is also tabled at this Health and Wellbeing Board meeting.
31.	The focus locally is to ensure greater integration of health and care services through more joined up working across the various care professionals. A multidisciplinary approach is being developed. This includes identifying those people who may need care and support early and ensuring that they are supported. This includes frail older people in Care Homes and preventing admission to hospital, where appropriate.
32.	The intention is to continue to increase the number and scope of Village Care Schemes and to develop wider opportunities for community involvement and volunteering using the voluntary and community sector.
33.	Securing this requires 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.

Issues	
Governance & Delivery	
34.	Improving outcomes for frail older people is one of the priorities within the Joint Health and Wellbeing Strategy.
35.	There is clear alignment with the Better Care Fund Plan and the emerging priorities of the Sustainability and Transformation Plan.
36.	Responsibility for the delivery of the outcomes rests with Director for Social Care, Health and Housing and the Director of Commissioning of the Clinical Commissioning Group.
Financial	
37.	None identified for this report.

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.
	Are there any risks issues relating Public Sector Equality Duty **No**
	If yes – outline the risks and how these would be mitigated

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

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Presented by Julie Ogley