



**North Somerset**  
**Joint Commissioning Strategy**  
**for**  
**Older People**  
**2010-2013**

**Draft for Consultation**

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## SECTION 1: INTRODUCTION

This joint strategy has been prepared by North Somerset Council and NHS North Somerset. It covers the years 2010-2013 and identifies how the needs of older people will be met within the available resources provided by North Somerset Council and NHS North Somerset during the period.

The key aim of the strategy is to achieve the transformation of services which deliver real control, meaningful choices and better outcomes for older people. In particular, NHS North Somerset and North Somerset Council are keen to develop a range of joint services which actively work to promote independence and reduce our use of institutional care options, be they hospital-based or in care home settings.

Services for older people with mental health needs are not specifically covered within this strategy. Whilst many of the services that are covered will be equally relevant to older people with mental ill health, there is a separate Joint Commissioning Strategy for older people's mental health services.

Acute, hospital services are clearly vital in supporting older people to live healthy and independent lives. This is true of all services but particular examples would be cataract, cardiology and care of the elderly services. This joint strategy does not specifically address acute services as these are addressed in other areas of the Primary Care Trusts Work. What is important is that the impact of any changes in demand that may arise from this strategy are taken account of. For example, we will assess whether more prevention services will mean that we see less demand for hospital based care.

It is however, important that we establish clear pathways for accessing acute hospital care, to ensure that people get the acute interventions that they need in a timely manner. The key element is about managing safe and timely hospital discharge through rehabilitation services and robust discharge arrangements; these issues are covered within this strategy.

This commissioning strategy is the joining together of the following plans developed within the individual organisations (with consultation with all parties):

- North Somerset Council – Older People Strategy
- North Somerset Council - Adult Social Care Review
- NHS North Somerset's Strategic Framework
- NHS North Somerset - Transforming Community Services in North Somerset

This strategy represents the joint ambitions across Health, Social Care and Housing for developing services to meet the needs of older people within North Somerset. It has been agreed at the Joint Transformation and Commissioning Board (TCB) (see Section 11 for more details) and ratified at through each organisation's internal mechanisms. This is a joint strategy and has been formally adopted through both Council and PCT processes. The term "we" is used throughout this strategy to reflect the joint intentions of both organisations; even where one organisation (NHS North Somerset or North Somerset Council) may hold the responsibility for providing the service in question and therefore will undertake a certain function or action but

that this is done with the full knowledge, agreement and sign up from the other partner.

Detailed annual action plans will be drawn up each year to deliver the stated objectives. Plans for year 1 are shown in section 9 of this strategy. Some objectives will be cost neutral, whilst others may require different levels of investment. Any new investment in new services will need a fully worked up business case and agreement from the funding organisation(s). Both the PCT and Local Authority are in an increasingly stringent financial position; any investment in new services will need to come from funding released, either from elsewhere within older people services (or elsewhere in the health and social care system).

As part of the action planning arising from this strategy, we will be investigating the impact on all parts of the health and social care system and ensuring a joint approach to delivery.

### **Commissioning Explained**

Commissioning has been defined as:

*“the process of translating aspirations and need into timely and quality services for users which meet their needs, promote their independence, provide choice, are cost effective, and support the whole community”*

Commission for Social Care Inspection

This means finding out what services people need and then deciding how we can best jointly commission those services. We need to ensure that we commission services that provide good quality and the best range of services that we can afford within the resources available. This means that we can't purchase everything that we would like to, and we have to decide which services are the most important. We also want to make sure that older people living in North Somerset, their families and their carers help us to make these decisions.

Good commissioning involves four main types of activity:

- **ANALYSING** - *making sure that you know how things are working at the moment, how much there is to spend, who needs the services and what national policies and guidelines have to be kept to.*
- **PLANNING** - *finding out where the gaps in service are, developing plans for the future and producing a commissioning strategy, which is based on both the analysis and the views of everyone concerned, especially the people who use the services.*
- **DOING** - *making sure that the services are delivered as planned and that if problems occur they are dealt with properly.*
- **REVIEWING** - *assessing the services on a regular basis and ensuring that they are still meeting needs effectively.*

These activities operate in sequence, and govern joint purchasing of services by North Somerset Council and NHS North Somerset.

### **Commissioning in North Somerset**

This strategy has been developed in consultation with the Older People Strategy Group and has been developed taking into account the latest national guidance, the views of local people, their families and their carers and a detailed analysis of local need and supply. Our aim is to jointly commission services that:

- Are based on a full understanding of Needs
- Are person centred and place people in control of the services they receive
- Promote health and independence
- Achieve best value and the best outcomes for older people in North Somerset.
- Promote effective partnership working across agencies.
- Ensure equality of access to treatment and services

This strategy will provide the main overall plan for the next 3 years, there will be an expenditure plan for each year to make sure that implementation of the services is done within budget and within the agreed priorities. We will report regularly on progress and achievements at the end of each financial year. The report will summarise our progress against the targets and objectives in the strategy.

We are committed to establishing joint commissioning arrangements as we see the following benefits:

- Established joint targets for health and social care community services, especially rehabilitation/ intermediate care.
- Assist in delineating the division between commissioning and provider services in Social Care.
- Effective use of budgets (e.g. the current Section 75 agreement for Community Equipment allows the PCT to benefit from reduced VAT payments).
- Maximise the use of commissioning resources / managers
- Ensure the impact on partner organisations of commissioning decisions is taken into account.

### **Practice Based Commissioning**

Practice Based Commissioning devolves responsibility for commissioning services from NHS North Somerset to local GP practices. This gives local clinicians' greater control over resources, freeing them to respond better to local and individual need.

This creates more patient centred provision of services, encourages innovation and clinical leadership across North Somerset to:

- Enable North Somerset to become the most effective health system in the UK
- Encourage true co-leaders in developing local services and health improvement programmes
- Bring financial balance

NHS North Somerset is committed to working with practice based commissioners, providers and partners to design and create services and health programmes that will best meet people's greatest needs as cost effectively as possible

### **Lead Commissioning**

By the term "lead commissioning" we mean, where one agency, either the Local Authority or the PCT, takes on the function of commissioning the service(s) that have been jointly agreed as needed. As part of the arrangement, we must decide which functions will be delegated to the lead commissioner, what will remain a joint responsibility and what should be an individual agency's responsibility along with what money to transfer to finance the services commissioned (either formally through a section 75 or by informal "aligned" budgets). Any Lead Commissioning arrangements will need to demonstrate clear benefits for the participants and signed off at the Transformation and Commissioning Board.

In order to pave the way for lead commissioning we have established the following components:

- a) A Joint Senior Management Group responsible for the Governance of the arrangements and for overseeing financial, commissioning and service performance. This high level strategic planning group is called the Transformation and Commissioning Board.
- b) A joint commissioning group responsible for translating the partnership agreement into commissioning strategies and actions and monitoring their implementation. This operational group ensures delivery of the agreed strategies and monitoring of commissioning and financial performance.
- c) Within NHS North Somerset there is a clear separation between commissioning and the provision of directly managed services; the council is also working towards a clearer separation with the introduction of the brokerage team and the strategic commissioning function separated from provider services.
- d) A series of joint planning group that involve a wide variety of stakeholders, including Council Members, Officers and Health Professionals, service users, carers, directly managed and external service providers.
- e) There is a Section 75 agreement which contracts for care on behalf of the NHS North Somerset's CHC team.
- f) A Section 75 agreement exists for community equipment where the local authority is the lead commissioner.

Part of this strategy will be to develop recommendations in relation to lead commissioning arrangements for older people within North Somerset.

The closer working arrangements between health and social care will provide opportunities for shaping and managing the provider market more effectively and should result in some savings.

## SECTION 2: STRATEGIC CONTEXT

### 2.1 National Drivers

#### 2.1.1 World Class Commissioning

The proposals in the White Paper *Our health, our care, our say* set the strategic direction for delivering healthcare with a greater focus on prevention, on promoting well-being and on delivering services in settings that are more convenient to the people that use them. The aim is to secure the NHS as fair, personalised, effective and safe, and which is focused relentlessly on improving the quality of care.

Improving commissioning is at the heart of delivering this agenda. Primary care trusts (PCTs) must become trusted community leaders, working with their local population, partners and clinicians, leading the local NHS.

World class commissioning is the term used to deliver a more strategic, long-term and community focused approach to commissioning services, where commissioners and health and care professionals work together to deliver improved local health outcomes. World class commissioning will enable the NHS to meet the changing needs of the population and deliver a service which is clinically-driven, patient-centred and responsive to local needs.

The Commissioning framework for health and well-being is designed to enable commissioners to achieve:

- a shift towards services that are personal, sensitive to individual need and that maintain independence and dignity
- a strategic reorientation towards promoting health and well-being, investing now to reduce future ill health costs
- a stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

World Class Commissioning identifies eight steps to more effective commissioning:

1. Putting people at the centre of commissioning
2. Understanding the needs of populations and individuals
3. Sharing and using information more effectively
4. Assuring high quality providers for all services
5. Recognising the interdependence between work, health and well-being
6. Developing incentives for commissioning for health and well-being
7. Making it happen – local accountability
8. Making it happen – capability and leadership

The World Class Commissioning Framework states that commissioners' role should be to develop the market in services, in order to encourage third sector providers who are thought by commissioners to be able to provide services which can achieve sustained improvement in particular outcomes.

Commissioning itself will increasingly take centre stage at local level, and will be assessed jointly by synchronising performance management systems.

A recently introduced concept in NHS commissioning is Quality Improvement Productivity and Prevention (QUIPP). This is an approach to managing the financial challenges within the NHS. In summary, it is the process of looking at how we can best use our existing resources to ensure that we are using it effectively, delivering quality services that can achieve the best health outcomes. We should focus on preventing ill health that will reduce the costs of secondary care interventions and use innovation and best practice from elsewhere to drive efficiency and quality. QUIPP will be a major tool that the NHS will apply to service redesign in the coming years.

### **2.1.2 Putting People First and Transforming Social Care**

The Local Authority Circular *Transforming Social Care* (2008), details the approach to personalisation; it is the way in which services are tailored to the needs and preferences of citizens. The overall vision being that the state should empower citizens to shape their own lives and the services they receive.

Therefore, everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity.

All individuals eligible for publicly-funded adult social care will have a personal budget (other than in circumstances where people require emergency access to provision); a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being.

It will mean working across the sector with partners from independent, voluntary and community organisations to ensure a strategic balance of investment in local services.

Across Government, the shared ambition is to meet the aspiration to put people first through a radical reform of public services.

Users' needs are changing, both growing and diversifying. The policy response is to seek to make public services themselves more diverse, using competition and choice in health, social care and housing markets, hoping to encourage a wider range of good-quality services to be created but at minimal cost.

Hence, the national agenda can be summarised as:

- Health and social care integration nationally and locally.
- Expanding the provider market particularly, community-based services.
- Shifting health and social care services into the community and giving individuals more control and responsibility for their own care.

A shift towards community-based services in these policy areas necessitates changes to housing strategy and the development of new technologies of care, such as support services available over the internet, and by telephone.

The focus for commissioning of services can be summarised as:

- Prevention of need – shared responsibility for outcomes in health and well-being.
- Personalisation – people in control and taking responsibility for their own care.
- Coordination and integration – whole system change.
- New healthcare technologies delivered in communities

### 2.1.3 Transforming Community Services

The NHS Next Stage Review: Our Vision for Primary and Community Care (DH July 2008) sets out a vision for the NHS of a modern, accessible and responsive community service which offers consistently high quality care. 90% of health care already takes place in the community; the vision anticipates even more health care being delivered outside of the acute sector and closer to the patient's home.

To deliver this vision, PCTs are told they need to:

- Understand the needs of their population,
- Understand the current supply of community services
- Assess to what extent current supply meets the assessed needs,
- Identify local priorities and specify what services are needed
- Stimulate the market to deliver the services which are required,
- Manage both demand and outcomes,
- Manage performance and evaluate.

Quality is at the heart of this transformation but to deliver the quality requirements, the organisation providing the bulk of community services, namely the PCT's provider arm, must also change and update its organisational structure. The Transforming Community Services Programme aims to deliver both the commissioning and organisational changes outlined above.

The aim is to move from a single profession, stand alone services (for example District Nursing) to a more patient/clinical pathway model.

The key elements of clinical transformation are safety, effectiveness and patient experience.

The quality framework sets out a quality improvement plan for:

- **World Class Commissioning** of community services (identifying needs, specifying services, understanding and developing markets and performance monitoring and evaluating)
- A new **national contract** for community services
- A national **information model** which is being finalised
- Moving from the current block grant system to **local currencies and tariffs**.

New organisational arrangements for the provider services will be introduced during 2010/11. In the meantime, provider services will be strengthened to be more independent and establish a clearer contract and set of requirements for the service.

#### **2.1.4 Lifetime Homes, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society (Feb 2008)**

The National Housing Strategy for older people *Lifetime Homes, Lifetime Neighbourhoods* (2008) estimates that while the proportion of older people will continue to rise, with the 75+ age group growing faster than any other, this older part of the population will also become more diverse in the characteristics of its individuals. This ageing of the population is predicted to be one of the greatest challenges of the 21st century for housing. The strategy sets out the response to this challenge by outlining plans to enable people to live out their lives, as long as possible, independently and safely with their families and friends around them. The aim is to create “lifetime homes” in “lifetime neighbourhoods” that are welcoming, accessible, and inviting for everyone, regardless of age, health or disability where local shops, local services, and the local park or leisure facilities are accessible to all.

The strategy sets out plans for making sure that there is enough appropriate housing available in future to relieve the forecasted pressures on homes. It aims to ensure that:

- people are able to make the right choices at the right time,
- there is the right range of choices of ‘specialised’ housing available for those who need more support.

It is acknowledged that housing is central to health and well-being, so services need to be planned and integrated to reflect this. These principles reflect what older people have said they want – above all, to be involved in determining what those choices must be.

Today, most of our homes and communities are not designed to meet people’s changing needs as they grow older. Older people’s housing options are too often limited to care homes or sheltered housing. Put simply, more and better homes for older people are needed, now.

A lack of suitable housing, impacts both upon the ability of health services to discharge patients, and the ability of social care services to provide suitable care for older people with particular impairments.

There is also a critical need for more and better information about the range of housing choices available to older people, particularly for people who are not in touch with statutory services and who need some practical help in order to stay in their own home.

#### **2.1.5 National Financial Context**

##### **2007 Comprehensive Spending Review (CSR)**

The 2007 spending review set out departmental allocations for 2008-09, 2009-10 and 2010-11. The CSR was based on a need to meet the challenges presented by:

- demographic and socio-economic change, globalisation, climate and environmental change, global uncertainty and technological change;
- how the UK and public services need to respond to these challenges;
- an ambitious and far-reaching value for money programme to release the resources needed to address the challenges, involving both further development of the efficiency areas developed in the Gershon review, and a set of zero-based reviews of departments' baseline expenditure to assess its effectiveness in delivering the Government's long-term objectives; and
- a more strategic approach to asset management and investment decisions, ensuring the UK is equipped with the infrastructure needed to support both public service delivery and the productivity and flexibility of the wider economy.

The Government's stated objective is to build a strong economy and a fair society, in which there is opportunity and security for all and at this time they stated that:

- spending in the NHS will increase by 4 per cent per year in real terms from £90 billion in 2007-08 to £110 billion by 2010-11;
- confirming the Government's public service priorities and setting all departments' budgets for the next 3 years with total public spending set to grow at 2.1 per cent per year between 2007-08 and 2010-11.

However, this was based on an assumption that:

- the economy is expected to grow by 3 per cent in 2007, and by 2 to 2.5 per cent in 2008;
- inflation is set to remain low and stable at around 2 per cent; and
- the public finances remain sound, with borrowing forecast to be £38 billion in 2007-08 and set to fall in every year for the next 5 years of the projection, and with debt lower than in the US, Japan, and the euro area.

Since the publication of the 2007 Spending Review there have been significant, well documented changes to the international economy. The government have been clearly indicating that there will be cuts in public sector spending which will be set out in the 2009 pre budget report.

The December 2009 Pre-Budget Report announced details of the £12 billion of savings to be achieved through delivering services in a smarter, more effective way and announced that £11 billion a year of these savings will be delivered by 2012-13, of which, £8 billion are savings identified as part of the Operational Efficiency Programme (OEP) through improving back office functions, IT, collaborative procurement and property running costs. The remaining £3 billion are additional to OEP.

### Summary of the National Strategic Context

There will be a greater focus on prevention, on promoting well-being and on delivering services in settings that are more convenient to the people that use them.

Services will be tailored to the needs and preferences of individuals, they will maintain independence and dignity and individuals will be well informed of what is available.

Citizens will be empowered to shape their own lives and the services they receive.

Service Development is expected to be achieved at the same time as delivering major financial efficiencies and savings.

## 2.2 Local Strategic Direction

### 2.2.1 Local Area Agreement

The North Somerset LAA entitled “Improving our communities” covers the period 2008 – 2011. The LAA is aimed at improving the quality of life for local people through better joint working practices and by strengthening local services. It is a key delivery mechanism of the Sustainable Community Strategy.

The new LAA contains 69 targets aimed at tackling local priorities and is based around four key policy areas:

- Children and young people
- Economic development and environment
- Health and wellbeing
- Safer and stronger communities

Of these 69 targets, the following are particular drivers for this strategy:

Priority Indicators	Baseline	2008-09	2009-10	2010-11
Achieving independence for older people through rehabilitation/ intermediate care <b>(NI 125)</b>	78% of older people discharged from hospital with an intention that they will move on/back to their own home 3 months after discharge	79%	80%	81%
Carers receiving needs assessment or review and a specific carers service <b>(NI 135)</b>	29% of carers	32% of carers	35% of carers	38% of carers
People supported to live independently through social services (all ages) <b>(NI 136)</b>	3152 / 100,000 population	3220	3485	3750
End of life access to	2006	18.0%	18.50%	20.26%

palliative care enabling people to choose to die at home <b>(NI 129)</b> Proportion of deaths at home registered within calendar year:	17.96%			
Increase the number of older people (65+) including carers with self-directed support packages	March 2006 Direct Payments 104 people (7.28%) Individual Budgets 0 people	15%	20%	No target set

### 2.2.2 NHS North Somerset Strategic Framework: Making North Somerset Healthier 2008 – 2013.

The corporate objectives of NHS North Somerset as set out in its Strategic Framework are to:

- Improve quality and earn autonomy by meeting all necessary targets
- Meet our challenges by innovative service redesign to meet identified needs
- Reduce health inequalities and promote health and wellbeing based on an understanding of health needs
- Be a competent commissioner and ensure the development of a fit for purpose provider service
- Be a good partner to work with – building public, stakeholder and staff confidence

These corporate objectives are enduring principles which underpin everything the PCT does and which are unlikely to change over time. Sitting alongside them are four Primary Goals which are specific improvements in health and wellbeing which will be achieved in the period 2008 – 2013.

Goal 1	To reduce health inequalities in all areas of our work, by targeting effort in the areas and population with greatest deprivation
Goal 2	Address the inter-related issues of care for older people, long term conditions, cardiovascular disease, cancer, self care, and increasing independent living at home
Goal 3	Work across boundaries to improve joint working in order to find new and radical solutions to systemic problems
Goal 4	To deliver safe and effective care by ensuring that systems and processes are efficient and reflect best practice

### 2.2.3 Transforming Community Services in North Somerset

The Transforming Community Services Strategy is an appendix to the NHS North Somerset Strategic Framework and covers all community health services regardless of provider. This includes a wide range of nursing, therapy and other services delivered to people outside of acute hospitals, often in their own homes. Some of

these services are provided in partnership with North Somerset Council and others are delivered by the independent and voluntary sector. It also considers services which are currently provided in hospital but which could be provided in the community in the future.

The Strategy does not consider primary care services such as GP, dental, pharmacy or optometry services.

The Transforming Community Services Commissioning Strategy supports the four primary goals of NHS North Somerset by aiming:

- to reduce health inequalities,
- address inter-related issues of care for older people, long term conditions, cardiovascular disease, cancer, self care, and increasing independent living at home,
- work across boundaries, and
- deliver safe and effective care.

The vision for future of community services has been developed on the assumption that, in the face of economic difficulties, the health care system will have to be more efficient and effective than ever before. There will need to be increasing emphasis on patients being supported to manage their own care and in ensuring they access the right level of care in the right setting when required.

The vision for self care in North Somerset is to develop “Health Shops” in all GP practices where patients can for example:

- find the latest information about their condition
- book on line on to exercise classes or borrow exercise DVDs
- pick up recipe books
- join expert patient programmes or support groups
- talk to a health professional

Health Shops could also be established in supermarkets, libraries or pharmacies and could be developed in conjunction with North Somerset Council’s Go4Life active lifestyles and healthy eating strategy. By opening up entry into self care, more people will be able to access at an early stage in their disease trajectory the tools which should prevent or slow down the progression of the disease.

Those patients whose health needs require more systematic management will need to be supported in the community by a range of professionals and support systems.

The services required to support patients in the community fall into two fundamental elements, urgent care and managed care. Within urgent care and managed care, there may be a number of components such as Rapid Response, Out of Hours Services and Emergency Care Practitioners in Urgent care and Direct Access Diagnostics, Rehabilitation and Community based Outpatient Clinics in Managed Care. The expectation is a move away from stand alone separate services to integrated pathway provision with the different components, if not delivered by one provider, delivered through partnerships between providers (NHS and other) with one lead provider being accountable overall.

Patients would only be seen in secondary care for Emergency Department Majors, complex surgery and those outpatient services which cannot be delivered in the community.

All other care should be managed in the patient's home or a community setting, though that community setting could be within Weston General Hospital for patients in the south of North Somerset and Clevedon Community Hospital for patients in the north.

A number of service gaps have been identified together with potential for shifting care closer to home. However, a number of the gaps in provision would be remedied by better processes and more systematic and consistent approaches rather than increased resources.

#### **2.2.4 Bristol Health Services Plan (BHSP)**

The Bristol Health Services Plan is an ambitious, wide ranging scheme to radically modernise and improve NHS health services in the Bristol area. The Plan involves changing how, where and when NHS health services are provided to improve the patient experience and treatment outcomes, and bring patient treatment and care closer to home. The Plan covers NHS health services in Bristol, South Gloucestershire and North Somerset – all the way from primary and health community care to hospital services.

The overarching goals of the Bristol Health Services Plan are:

- To provide better care closer to home: A far greater proportion of services will be provided in or close to people's homes.
- Improved service integration that will enable patients to access primary and specialist care in an efficient way.
- The centralisation of some specialist inpatient services such as paediatrics and ENT to enable the concentration on one site of specialist expertise in accordance with national standards.
- To enable a more systematic provision of secondary and tertiary hospital services.
- Flexibility to allow contestability for services with the Independent sector.
- Buildings that provide high quality environments for staff and patients.

The BHSP Service Design programme areas include Urgent Care, Cardiac, Cancer, End of Life, Sexual Health, Children's, Diabetes, Respiratory Medicine, Rehabilitation, Mental Health, Maternity and Newborn, and Elective Care. In addition there is a special project in acute myocardial infarction and acute stroke and TIA, and a service review in Breast Care.

#### **2.2.5 Putting People First in North Somerset**

By 2011 North Somerset will be expected to have in place the following core components:

- **Integrated working** with the NHS and wider local government partners along with a strategic shift of resources for care and support away from intervention at the point of crisis to a more pro-active and preventative model.
- A **commissioning strategy**, which stimulates development of high quality services that treat people with dignity and maximise choice and control whilst balancing investment in prevention, early intervention/re-ablement and providing intensive care and support for those with high-level complex needs. There should be joint support for third/private sector innovation, including social enterprise.
- Universal, joined-up **information and advice** available for all individuals and carers, including those who self-assess and self fund, which enables people to access information from all strategic partners. Links to advocacy and support services will need to be considered where individuals do not have a carer or in circumstances where they require support to articulate their needs and/or utilise the personal budget.
- A framework for proportionate contact and social care **needs assessment** to deliver more effective, joined-up processes. Greater emphasis on (assisted) self assessment, enabling social workers to undertake more appropriate assessments and spend more time on support, brokerage and advocacy.
- For people eligible to receive council-funded support:
  - **Person centred planning** and self-directed support should be the norm, with individuals having choice and control over how best to meet their needs.
  - A simple, straightforward **personal budget** system, which will lead to maximum choice and control being in the hands of people who use services.
  - Mechanisms to **actively involve family members** and other carers as expert care partners, with appropriate training and practical support to enable carers to develop their skills and confidence.
  - An enabling framework to ensure people can exercise choice and control with **accessible advocacy**, peer support and **brokerage** systems with strong links to user led organisations. Where user led organisations do not exist, a strategy to foster, stimulate and develop these locally.
  - An effective and established mechanism to enable people to make supported decisions built on **appropriate safeguarding arrangements**.
  - Effective **quality assurance** and benchmarking arrangements and effective local information systems to capture inputs/outputs and outcomes for individuals to support local quality assurance.

Councils will also be expected to have started to develop:

- A **market development** and stimulation strategy, either individually or on a wider regional basis with others, with actions identified to deliver the necessary changes. This may include a transformed community equipment service, consistent with the retail model.
- A local care **workforce** with the capacity and capability to deliver choice and support individual control, with staff who are appropriately trained and empowered to be able to work with people to enable them to manage risks and resources and achieve high quality outcomes.
- An approach that demonstrates an effective use of the available resources and meets the 3% **efficiency targets**.

In the longer term, all councils with adult social services responsibilities should take a balanced approach to prevention and early intervention and deliver personalised services, enabling individuals or groups to develop solutions that work for them. Key components should include:

- Everyone eligible for statutory support should have a **personal budget** - a clear, up-front allocation of resources. The council or a third party may manage this on behalf of an individual. Alternatively, people may choose to take all or part of this budget as a direct payment, with access to appropriate support to enable real choice and control.
- A strategic balance of investment between enablement, **early intervention or prevention** whilst ensuring suitable provision of intensive care and support for those with high-level complex needs.
- Responding to the developing national approach, a move to wider information sharing through the **common assessment framework**.
- An established mechanism to ensure that views and experiences of users, carers and other stakeholders are central to every aspect of the reform programme.

### Measuring Success

There are four areas on which councils and their partners should focus to help make sure services become more personalised and to get the right results for people. These areas link together and are shown in the diagram below:



- a) **Universal Services** - general support and services should be available to everyone locally including things like transport, leisure, education, health, housing, community safety and access to information and advice.

These services are important in everyone's lives, not just those people with care and support needs. Universal services work best when everyone can get the information, advice and support they need readily and easily to be able to use them effectively.

An indication of success would be that the local public transport system is set up to enable older and disabled people to attend hospital appointments and social/education activities easily and with confidence.

- b) **Early intervention & prevention services** - Support should be available to assist people who need a little more help, at an early stage to stay independent for as long as possible. These include things like support to recover from the effects of illness and help to manage a long term condition from someone with experience of a similar condition. These services also include help to safely maintain home and garden, training to get a job or return to work after a break, or support to start taking some exercise.

Not only do these early interventions make sure people can stay in their own homes for as long as they want, but are also the best way of keeping the costs down in the future.

Success would mean people were supported to get the right exercise and equipment following a fall so they would not have to go into hospital, and could stay at home without significant risk of falling again. Alternatively, through effective use of telecare people with dementia are routinely able to stay at home with their families, who are able to continue their everyday lives.

- c) **Choice and Control** - Self-directed support means having services available to meet people's needs rather than people having to fit in with the things on offer.

People who need support should be able to choose who provides that support, and control when and where the services are provided. The right information and advice needs to be available to help people decide. Some people will need extra help to negotiate their support and may need advocates to help them. It is important that people can take responsibility for themselves, and that councils and other advisers are not limiting their advice about what is possible.

Systems should be easy to follow and everyone involved should work together with the person at the centre of the plan. This is true whether the council is providing the support or people are buying the services themselves. To do this planning, people (or their advocates and supporters) need to understand what money is available to spend on their support. If it is their own money, they need to know what support there is locally, and that it is of a high quality and safe for them to choose.

For example, they can make their own plans for services with the money from the council. They can also get together with friends to make the plans together, or they can ask an agent or the council to arrange things for them.

Success would mean people in the community who need support and their families and carers feeling empowered to come up with flexible solutions to meet their needs, individually or collectively. People feel they have a life rather than a set of services.

- d) **Social Capital** - Everyone has the opportunity to be part of a community and experience the friendships and care that can come from families, friends and neighbours. This should be done without putting an unreasonable burden on friends and family who want to help. Carers need to be recognised and supported in their role and they need a life of their own outside caring.

Positive interaction may be seen in many ways, it includes church groups and other faith communities, where people are encouraged to be interdependent, supporting each other in different ways. It is also about older and disabled people being full members of the community.

People who have support needs, their carers and others who find support difficult to access need to be encouraged to be part of those discussions about community life. Society should support them to influence decisions and build wider relationships through opportunities like volunteering. Evidence of success would be community groups working with the council to put good ideas into practice to make the area a better place for older and disabled people.

### **2.2.6 Adult Social Care Review**

The Adult Social Care Review was carried out in 2008 and creates an action plan for North Somerset in achieving the outcomes set out in “Putting People First”. The review recommends that the focus should be on preventative services in order to meet the personal care needs of older people and to achieve more effective use of the overall budget across health and social care. The following outcomes provide the focus for the way forward:

- A range of preventative service and good quality housing in the community to meet the needs and sustain the changes.
- Reduced numbers of older people entering care homes for personal care.
- Reduced numbers of older people entering care homes for nursing care.

A new service design is proposed to help prevent older people from having to go into residential or nursing care, and will help them back into their own homes after short stays in hospital, residential or nursing care. The services will:

- Enable older people to lead full, active and healthy lives for as long as possible.
- Enable older people to live independently in their own homes for as long as possible.

The development and implementation of this new model for services bring the opportunity for savings which will offset some of the additional investment needed to supplement existing preventative services.

### **2.2.7 North Somerset – Older People Strategy**

The North Somerset – Older People Strategy brings together the work in all Directorates of the Council relevant to older people and to ensure that this work is coordinated, consistent and relevant to the wishes and aspiration of older people in North Somerset.

The following outcomes are highlighted which are derived from the 2006 white paper “Our Health Our Care Our Say”:

- 1 - Improved Health
- 2 - Improved Quality of Life
- 3 - Making a Positive Contribution
- 4 - Exercising Choice and Control
- 5 - Freedom from Discrimination and Harassment
- 6 - Economic Wellbeing
- 7 - Ensuring Personal Dignity

Review of the strategy has taken place and plans are underway for development of a new strategy from April 2011. This will be a joint strategy and will encompass all the members of the North Somerset Partnership.

The Older People Champions Group and the Older People Strategy Group will oversee the development of the new strategy. Its development will be guided by a steering group whose membership will be drawn from across the members of the Partnership, older people, carers, and other key statutory and voluntary sector organisations.

### **2.2.8 North Somerset's Older People Housing Strategy**

The North Somerset Older People Housing Strategy covers the period 2007 – 2010. The overall aim of the strategy is to *'Ensure older people have access to a range of housing and housing related services that enable them to remain independent and lead a full and active life.'*

The strategy identifies the following key issues that are being faced:

- An ageing population
- Lack of awareness of what services are available and who to turn to for advice on housing and housing related issues.
- Meeting decent homes standards in the owner occupied sector
- Access to affordable warmth
- Pressure on Disabled Facilities Grant budget
- Uncertainty of Supporting People funding
- Appropriate housing options to meet changing needs
- Planning for extra care housing

The key priorities identified are:

- Providing High Quality Information and Advice Services for Older People
- Provision of Decent, Accessible, Warm & Safe Homes for Older People
- Promoting Independence
- Increasing Housing Choice

The strategy puts in place action plans to ensure that:

- Information and publicity is widely accessible detailing the services that are available to help older people make informed choices about their housing and housing related needs including planning for the future.
- Creating a new small works grant to complement Decent Homes Assistance, meeting identified need in relation to home maintenance and develop a range of incentives to deliver energy efficiency improvements.

- Establishing a disability housing register of adapted properties and increase use of recycled equipment.
- Ensuring a range of accessible housing is available that meet the Lifetime Home Standard.
- Maximising funding for affordable housing.
- Working in partnership with all stakeholders to meet older people's housing needs.

The Housing Strategy 2010 and beyond is due to be adopted by the end of March 2010, this will give a broad overview of how we aim to meet all housing need. Following on from this we will be developing an older people's delivery plan to sit within the new corporate Older People Strategy. This will also inform developments within Supporting People in relation to housing related support services for older people.

### **2.2.9 Local Resource Planning**

NHS North Somerset and the Council are proud of its services to older people. Care for older people is one of nine agreed priorities of the Council. However we are concerned at the impact of the continuing growth in health and adult social care spending.

The council have embraced the Government's efficiency agenda, with a strong track record of delivery of efficiency savings. This has involved working collaboratively on a range of projects, including the development of a Homecare re-ablement service, electronic scheduling and monitoring and shared financial services with PCT and DWP generating additional income and benefit take up.

In addition income has been maximised by efficiently applying charging arrangements to all services.

The Comprehensive Spending Review signals only a very modest real terms increase in local authority spending, insufficient to keep up with population growth.

Local opinion indicates that Council Tax has reached an affordability limit, with the impact of the increases over the past ten years having fallen particularly hard on the district's disproportionately older population. As a consequence, the Council has set a clear target to limit increases in Council Tax to less than the rate of general inflation, especially given the deteriorating economic position.

In addition, the draft Regional Spatial Strategy allocates a house building target of 26,000 new homes to North Somerset in the period to 2026, as a significant contribution to the West of England growth point. While concerned at the potential impact of such intense development, the Council is determined to ensure that sufficient infrastructure and community facilities are provided in order to provide cohesion to these new communities.

The Council faces stark choices in future spending decisions, acknowledging the tight outlook for public spending and are committed to managing costs within limited resources.

The PCT has been provided with analysis to demonstrate the potential productivity improvement that can be delivered across North Somerset health services. Plans are being developed under the auspice of a Quality, Innovation Productivity and Prevention programme (QIPP) and will deliver productivity and quality improvements to fund cost pressures due to demographic growth and technology. Changes will include revised care pathways and redesigned services.

We remain committed to a service with quality as its organising principle through a period of expected significant financial challenge. We recognise the challenge is to find ways in which services are developed that apply innovation to deliver productivity and quality.

### **Summary of the Local Strategic Context**

Agencies will work together to make available, better integrated health and social care services for older people.

Community based services will be available that will enable older people to lead full, active and healthy lives for as long as possible and to live independently in their own homes for as long as possible.

Services will be rated as high quality, innovative and meet identified needs

The health and social care system will be more efficient and effective than ever before. There will be increasing emphasis on patients being supported to manage their own care and in ensuring they access the right level of care in the right setting when required.

The focus will be in enabling older people in North Somerset to make a positive contribution to their own quality of life and to their community.

## **2.3 Linked Strategies**

### **National**

[End of Life Strategy](#)

[Stroke Strategy](#)

[A new ambition for old age: Next Steps in implementing the NSF for Older People](#)

[NSF for Long Term Conditions](#)

[Use of Resources in Adult Social Care](#)

### **Local**

[Older People Strategy](#)

[Older People Mental Health Joint Commissioning Strategy](#)

[Carers Strategy](#)

[Learning Disability Joint Commissioning Strategy](#)

Learning Disability Self Assessment Action Plan

[Housing Market Assessment for Older People](#)

[Safeguarding Adults Policy](#)

[Joint Engagement Strategy](#)

[Go4Life - Active Lifestyles](#)

Putting People First Milestones Framework

[Draft Physical and Sensory Impairment Strategy](#)

[Transforming Community Services \(Summary\)](#)

North Somerset LINK Health & Adult Social Care  
Priorities Survey Report

### **SECTION 3 Current Commissioning Arrangements**

NHS North Somerset and North Somerset Council are increasingly working jointly to manage the commissioning and contracting arrangements in North Somerset for social care and health services, where interfaces exist. Section 11 to this document sets out the planning framework and governance arrangements.

The aim is to ensure joint infrastructure issues are appropriately managed and to maximise the opportunities for joint work to achieve increased efficiencies and improved outcomes across community health and social care.

In recognition of increasing demands of an ageing population, a range of measures have been taken to deliver more efficient working, increase resources and improve outcomes for older people. We have worked in collaboration with CSED and have been innovative and well advanced with its efficiency programme. The following initiatives are already underway:

- Four integrated Primary Care/Adult Social Services community teams have been established as part of North Somerset's POPP project. The aim of integration is to ensure that service users receive a single unified response from health and social care services in North Somerset, that access to services is improved and duplication of information and effort eradicated ensuring that service users are not confronted with multiple assessments or requests for information.
- Management of Rapid Response services and Intermediate Care services is integrated with a single manager taking responsibility for the joint service (including falls).
- Our Integrated Community Equipment Store achieves consistently high performance in partnership with NHS North Somerset. Access to equipment is provided rapidly and in emergency can provided within hours.
- The Council and NHS North Somerset have cooperated to implement the new criteria for Continuing Health Care. Procedures have been agreed and joint work is being undertaken to assist NHSNS with procurement of services and payment of fees. The NHS component of nursing care fees is paid to care homes via a partnership arrangement with the Council
- NHS North Somerset and the Council already invest in domiciliary support on discharge through our joint intermediate care services. We also provide some residential based support (Clevedon Hospital and step down places).

<b>Jointly Commissioned Services</b>	<b>Local Authority</b>	<b>Health</b>	<b>Total</b>
3rd Sector low level support services	197,000	75,000	272,000
Equipment & Adaptations	546,690	820,000	1,366,690
Rapid Response & Rehabilitation	466,030	1,624,413	2,090,443
Single Point of Access (SPA)	290,550	171,982	462,532
Carers Service	184,667	84,203	268,870
	<b>1,684,937</b>	<b>2,775,598</b>	<b>4,460,535</b>

<b>Local Authority Funding on Services for Older People</b>	<b>2009-2010</b>
<b>Prevention and Self Care</b>	<b>£ 1,889,055</b>
“Front Door” Service	
<i>Low Level Support Services</i>	
Payment to 3rd Sector	
Community Meals	
Supporting People Services	
<b>Early Intervention</b>	<b>£ 11,872,660</b>
Extra Care Housing (Care Provision) <sup>1</sup>	
Supported Living (Care Provision) <sup>1</sup>	
Telecare	
<i>Respite Care and Short Stay Breaks</i>	
Care in Residential Homes	
Respite Care	
Short Term Placements	
Day services	
<b>Access to Services</b>	<b>£ 695,200</b>
<i>Single Assessment Process (SAP)</i>	
<i>Self Assessment / Mediated Assessment</i>	
<i>Brokerage</i> <sup>2</sup>	
<i>Direct Payments/ IB</i>	
<b>Community Based Managed Care</b>	<b>£ 19,824,100</b>
<i>Locality Teams</i>	
<i>Home Care</i>	
Domiciliary Care – in House	
Domiciliary Care - Purchased	
<i>Care in Nursing Homes</i>	
<b>Total</b>	<b>£ 34,281,015</b>

### Notes

- 1 *Extra Care Housing and Supported Living – This is the care element only, support is included in the figure for SP Services and capital investment is not shown.*
- 2 *Brokerage - 2/3rds of the care commissioned is for older people this has been apportioned accordingly*

NHS North Somerset analyses spend according to morbidity, rather than age, as such it is not possible to analyse fully the amount spent under each heading listed above. The following Table shows the amounts spent by NHS North Somerset in the areas listed, but again this is in the main but not specifically for older people:

<b>Service Area</b>	<b>2009-10 Budget</b>
Community Matrons	£505,575
District Nurses	£2,763,270
Occupational Therapy	£477,811
Community Physiotherapy	£432,509
Podiatry	£563,718
Continence	£357,246
Specialist nurses TVN	£67,621
Clevedon hospital	£1,637,389
Falls	£97,291
Funded Nursing Care <sup>note 1</sup>	£4,915,000
Continuing Health Care <sup>note 2</sup>	£4,415,000
<b>Total</b>	<b>£16,232,430</b>

**Note 1** - The FNC budget covers all nursing homes placements irrespective of age and condition.

**Note 2** – The CHC budget excludes those with Learning Disabilities as a significant majority are under 65 years of age, but does include people with physical disabilities and mental ill health as very few people are under 65.

In addition NHS North Somerset spends a significant amount of money on hospital care for older people, as well as primary care services and pharmacy. Again, this spend is not analysed by age group. Over time our intention is to identify ways to invest this money in alternatives to hospital care to deliver our strategic objectives of delivering more care nearer to home and in community settings.

In drawing together this strategy, we will dedicate resources to undertake further analysis to give a full picture of the amount of money being spent in this area.

## SECTION 4 Summary Needs Assessment

The White Paper *Our Health, Our Care, Our Say* (2006) illustrates that demographic change to the population through ageing is one of the greatest strategic challenges facing the UK today. Nationally, the number of people with longer-term healthcare needs is estimated to rise by 75% for those aged 85 and over by 2025.

The majority of NHS and Social Care activity is directed at those older people with the highest level of need. A change in approach to meeting both health and social care needs more generally is therefore necessary.

The National Housing Strategy for older people *Lifetime Homes, Lifetime Neighbourhoods* (2008) estimates that while the proportion of older people will indeed continue to rise, with the 75+ age group growing faster than any other, this older part of the population will also become more diverse in the characteristics of its individuals. There will be, more men, more people from black and ethnic minority backgrounds, more older people suffering dementia, more older people with disabilities and more older people living alone.

Older people living alone will account for a quarter of growth in the number of households, putting ever greater pressure on general housing supply. Older people living alone will put pressure on general housing supply; there will be increasing pensioner poverty and housing not meeting decency standards, on average across the district 80% of those over 65 are owner occupiers. In addition there will be greater concentration geographically of both pensioner poverty and housing not meeting decency standards in rural areas and in particular deprived urban areas. The Social Exclusion Unit's report *Sure Start to Later Life* (2006) states that 1.2 million pensioners are currently multiply socially excluded, with the South West of England having a higher than average rate of multiple exclusion amongst older people. In North Somerset it is anticipated that between 2008 and 2025 the population of those living alone aged over 75 years will increase by 58% and by 80% for men, indicating a potential increasing demand on support and care services with the possible onset of frailties.

North Somerset's JSNA for older people<sup>1</sup> reports that there is a greater proportion of its population in the over 65 age range than the national average. Based on the 2006 mid year estimates (2001 census), it identifies that North Somerset's older population is estimated to grow constantly over the next 20 years; there will be a 16% increase in the number of people aged 85 by 2015 and 62% increase by 2025.

The steeply rising number of "younger" older people shows how essential it is that we develop preventative health and social care services. The aim of these services will be to offer low level care and support so as to prevent people needing more intensive services for as long as possible.

The recommendations identified in the North Somerset JSNA for Older People have been used as a basis for this joint commissioning strategy.

<sup>1</sup> <http://www.northsomersetpartnership.co.uk/usefulinformation/jsna/jsnaolderpeopleassessment1.asp>

A combination of loss of physical mobility for one in four of the over 75's, and the fact that some of the rural areas and villages fall in the worst 10% nationally for barriers to housing and services, indicates that for people living in this area, accessibility of services will be particularly important.

When compared to local authorities in England with similar characteristics to North Somerset, North Somerset has the highest number of care home places for older people proportional to the over 75 population and a consequent high number of people living in care homes; the majority of which fund their own care costs. There is evidence that older people in North Somerset are not aware of the options available that offer alternatives to a moving to a care home.

The PCT is in the top quartile nationally for providing intensive support in patient's own homes and more carers receive services than any other similar authority. Carers make a significant contribution in supporting people to live at home.

Similar to national forecasts, the ethnic diversity within North Somerset appears to be increasing. The Somerset Race Equality Council has produced a report looking at the ethnic profile of North Somerset based on ethnicity data from hospital admissions, the school census, NI registrations and births. It estimated that since the census the Black and Minority Ethnic (BME) population has probably doubled, but still represents a comparatively low proportion of the population at 4.8%. However, the increase is in younger working age groups and families with young children.

The challenge this poses for commissioners is how, in this context, to commission services which meet individual need.

North Somerset has the biggest social inequalities gap in the South West and the eleventh biggest inequalities gap in the country (only 10 other local authority areas have a wider gap between their wealthiest and poorest communities). Some areas (in Central Weston-super-Mare) are in the 2% most deprived areas in England. Whereas some of the more rural areas of North Somerset fall in the bottom 10% nationally, for barriers to housing and services, leaving people potentially isolated with poor access to services.

Three electoral wards stand out as having a population with the poorest health outcomes in North Somerset. These are also the areas of greatest social deprivation, and are all situated in Weston-super-Mare.

Overall life expectancy in North Somerset is higher than national rates and similar to rates across the South West. The four main causes of death at all ages and of those who died prematurely (before reaching their 75th birthday) were cancer, coronary heart disease, stroke and circulatory diseases other than CHD and stroke.

Our study of health inequalities has identified that coronary heart disease, accidents and chronic obstructive airways disease are the most significant conditions which contribute to the higher number of premature deaths of men in Weston-super-Mare South and Central wards. For women the conditions are coronary heart disease, other cardiovascular disease and stroke.

Many of the relevant White Papers, Strategies, reports, reinforce the point that older people also make significant contributions to society. They provide large amounts of informal care that might otherwise have to be met through the public purse, and they are also prolific as formal volunteers, providing other services to the public.

## **SECTION 5 Shared Vision for Older People**

Health and Social Care services in North Somerset will be integrated, more efficient and effective than ever before; they will have a new prevention-focus that will help older people manage their own situation with the necessary support from personalised commissioned services.

Where urgent care is needed following a crisis situation, this will be managed in the community, either in the patient's own home, a community hospital, an urgent care centre or minor injury unit. We will enable the patient to stay in their own home if possible, by providing community IV therapy, telecare and nursing and AHP input where needed.

If following a crisis situation, the patient cannot remain in their own home; they will receive a coordinated assessment of need, enabling the patient to return home with improved coordinated support networks as soon as possible.

Service Users, Carers and Family members will be at the core of any service developments and will be fully involved in planning and delivery processes.

The Service Map for North Somerset will include the following services:

### **A new prevention and 'Front Door' service**

There will be a new emphasis on prevention to enable older people to live safely and healthily in their own homes. This will include promoting healthy life styles, making social contact, preventing falls and giving more support to carers.

A new 'front door' problem solving service will offer information, advice and help about the full range of older people's facilities and services, and will be able to respond to the new 'information prescriptions' in relation to health matters, the limits of funding arrangements and will be fully linked in with any "health shops" as they develop.

The function will go beyond signposting and will help individuals problem solve, it will identify risk and produce solutions in cooperation with clients. It will not rely on leaflets but will be available in person, by telephone and by the internet.

The service will be complemented by a service for older people being discharged from acute hospitals in the area, including self funders, and it will inform people on the options available following discharge from hospital.

It will link closely with existing front line facilities and also link to low level support from across the voluntary sector, including transport, gardening service, minor repairs, useful 'gadgets', lunch clubs etc.

### **A new assessment process.**

Those needing support and funding will be assessed using a new streamlined approach, in line with the personalisation agenda, which will involve a high level of self-assessment and mediated self assessment.

The assessment process will be outcome focused, in line with all older people's

services. Development work relating to the new single assessment process system is already underway and after the initial phase of implementation will expand into self-assessment.

Following assessment, individuals will agree care plans with their professional contact. The new initiative from Health introducing self-management plans, relating to chronic disease being managed in the community, will complement the arrangement.

### **A new brokerage service.**

All individuals, whether or not they require funding at this stage in their lives, will have access to a central brokerage service. Initially, the service will act as the broker between care management and the provider services. As, individual budgets take hold, the brokerage service will facilitate the Resource Allocation System, will explain the process for accessing services, explain charging/funding mechanisms, put people in touch with service providers and generally support them in the process of translating care plans into action. It is also envisaged that in the future brokerage will include the newly proposed 'Health Budgets.'

### **New locality teams**

Four new integrated care teams have been developed to deliver care to their local communities in Weston-Super-Mare, Worle, Clevedon/Portishead and Nailsea. The teams will focus on helping people to resolve both health and social care problems and will have the specific brief to help them function well and safely in their own homes.

The teams will be critical to establishing close working links with GP practices to help achieve the new service outcomes. Care plans will be outcomes focused in order to measure their impact.

The new locality teams will be supported by a number of specialist central teams, which will include the central hub for stroke patients and the new technology and resource centre described below.

### **A new telecare, telehealth & equipment service**

The service will be responsible for assessing, arranging and in some cases fitting, telecare and telehealth devices in the homes of individuals, in accordance with care plans. It will also oversee all equipment and adaptation to individual homes.

This team will be a strong and direct contributor to the concept of enabling people to remain in their own homes or sheltered/extra care housing and will help prevent people from having to be admitted to hospital. Telehealth proposals are currently being considered by NHS North Somerset's business planning processes. If we can demonstrate they are effective in managing demand elsewhere in the system (e.g. reducing hospital admissions) Telehealth may be introduced in the PCTs operational plan

### **An expanded rehabilitation services**

Older people who enter care homes do so with the onset of more complex health issues, on discharge from hospital or following a personal crisis such as bereavement. Sometimes, a short stay in a care home can be beneficial but often,

by default becomes a permanent solution.

The Rapid Response and Rehabilitation (RR&R) service comprises social workers, OT's Rehabilitation Assistants & Physiotherapists has the role of helping people over a crisis or rehabilitating them and helping them return home after a stay in hospital or personal/nursing care. The team has a clear outcome focus, which is to enable people to stay within, or return to, their own homes or community accommodation.

A small number of "step-down beds," for the rehabilitation of clients with more complex needs will be built into the network of services.

RR&R is supported by START (short term assessment and re-ablement team), which is composed of home care staff, who focus on maximising independence in the first 6 weeks of being referred by ICT or care managers. This specialist service will be reinforced to cope with the increasing demands, which at the present time it is unable to meet.

### **Home care**

Fundamental to the success of the new regime will be a strong, reliable and effective domiciliary care service.

### **Improved access to quality housing**

A key ingredient for the success of this approach will be having sufficient and fit for purpose accommodation in the community; this will include extra care housing and sheltered accommodation.

It should also be noted that as more householders are enabled to remain in their own home, there will be an increasing demand for DFG's to make adaptations to facilitate this.

It is crucial that the housing policy is driven by this strategy and for ASS&H to work in close partnership with a range of housing providers to meet these strategic priorities.

### **Community Hospital**

Marina Health Care Centre in Portishead opened in April 2009 to provide out patient and community clinic services across North Somerset. Also Clevedon Hospital will gradually change its use to become a community resource for North Somerset and will provide out patient services and some hospital beds.

Community hospitals are part of the longer term NHS policy for shifting the balance from acute hospital care to community based services. This will add a new dimension to community services and will be particularly helpful for those with long term conditions and will help prevent some admissions to large acute hospitals. The hospital will specialise in diagnostic, ambulatory care and rehabilitation services for older people.

The PCT also has a major project in the planning stages to develop a new Clevedon community hospital. This will provide more opportunities for rehabilitation beds and outpatient activity.

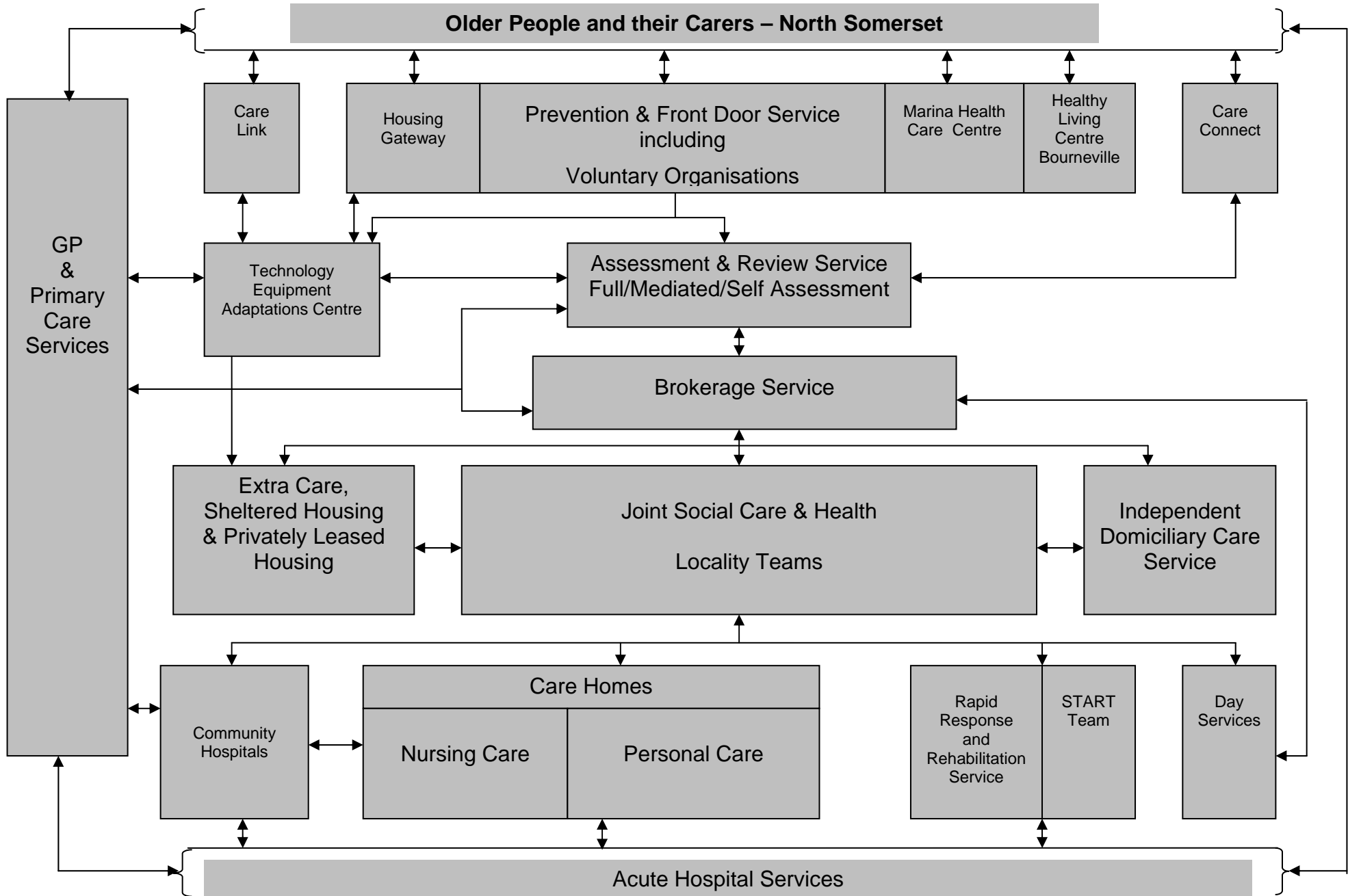
### **Integrated computer systems**

There is an overwhelming need for the different components of the health and social care system to come together into a consistent whole and for there to be seamless transfer of information between the two agencies.

The commissioning strategy will play an important part in this but it will also be dependent on the synchronisation and integration of information systems across agencies over time. The recently agreed development of SWIFT (AIS) will be an important step in the right direction. This offers the following features, which will greatly enhance joint working and make existing arrangements more efficient:

- Exchange of assessment and care planning information between local authority and local health systems
- Mobile working of social care and health staff
- Self-assessment/self-referral/automated sign-posting
- Personal budgets including individual client service funds and account statements.

**North Somerset Council & NHS North Somerset  
Social Care and Primary Care Service for Older People Service Configuration**



## **SECTION 6 Delivering the Vision**

This section looks at how the local services will change or develop to the vision for older people in North Somerset.

### **6.1 Prevention and Self Care**

#### **6.1.1 “Front Door” Service**

We will create of a new ‘front door’, problem solving service offering information, advice and help about the full range of older people’s facilities and services.

Community agents will be based in local neighbourhoods and will provide this first contact point for the host of services available to older people in their own homes. The service will target people who have historically funded their own care, often without advice, information or support from health and social care. The majority of older people in North Somerset fall within this category. The service will also encompass older people being discharged from hospital.

Community Agents will be proactive in the identification of people in need of support and in helping them to access existing services. Where necessary, the community agents will help people to access services via “Care Connect” (the single or central point of access for health and social care services).

The scheme will include responsibility for the development of the Community Café scheme and in identifying gaps in services that are needed to help people stay independent.

#### **6.1.2 Health Shops**

The vision for self care in North Somerset is to develop “Health Shops” throughout North Somerset where patients can for example:

- find the latest information about their condition
- book on line on to exercise classes or borrow exercise DVDs
- pick up recipe books
- join expert patient programmes or support groups
- talk to a health professional

These will be sited where they are most easily accessible, and we would hope to start in our more deprived areas. Health Shops may also be established in locations such as supermarkets, libraries, GP surgeries or pharmacies and could be developed in conjunction with North Somerset Council’s Go4Life active lifestyles and healthy eating strategy. The first will be located at The Boulevard in the centre of Weston-super-Mare.

By opening up entry into self care, more people will be able to access at an early stage in their disease trajectory the tools which should prevent or slow down the progression of the disease.

#### **6.1.3 Low Level Support Services**

Low level prevention initiatives were part of the sustainable North Somerset Partnership for Older Peoples Project services. Community Development Workers are employed by Age Concern Somerset and Somerset Racial Equality Council.

The Community Development Workers offer low level prevention support and sign posting services to isolated, vulnerable older people, they support Community Cafes, and undertake intergenerational work between older people and school age children. They support community sustainability through the development of local groups that promote inclusion, involvement and empowerment to take better care of oneself.

There may be opportunities for commissioning some services with the Local Authority leisure services – for example pulmonary rehabilitation programmes, cardiac rehabilitation, slimming clubs and exercise classes, disease prevention and weight management for people with diabetes. This would build on current initiatives such as Active Lifestyle and Go4Life, but might be specifically targeting people with particular conditions. Commissioning these services in conjunction with the Local Authority would help improve efficiency, uptake and access, and maximise use of current resources such as gyms, swimming pools etc

#### **6.1.4 Prevention of social isolation**

There are a range of services available for older people living in their own home that can help prevent social isolation. We have commissioned new services following feedback from older people within POPP and will keep under review the need for new developments in this area.

In addition, there is a range of housing related support (Supporting People) services for older people aimed at providing low level support to help people stay independent. Services exist within Sheltered Housing and on a floating support basis, providing housing related support to people living in owner occupation, private rented and social housing.

In addition we have commissioned some additional supporting people services including a Home from Hospital Service and the “Together” Service which is helping to develop volunteering for Older People and provides a social link for older people who may be lonely or isolated, particularly in rural areas.

#### **6.1.5 Self Care**

Self Care plays a key role in supporting people to prevent disease, manage their condition when they become ill and care for relapses when they arise or prevent them from becoming ill. Self Care is one of the key building blocks for a patient centred service and in essence aims to support patients to self care.

Research from the Department of Health shows that patients and carers confidence in managing the condition is greatly improved, less anxiety and depression, improved independence and feeling of self worth. Helping people to care for their long term condition empowers them to take more control over their lives.

We will develop resources to enable the maximum number of people be supported to self care. This will include:

- developing the skills of professionals to support self care,
- improving the provision of information about long term conditions through information prescriptions for example,
- introducing person-centred condition specific self-management plans that empower patients to recognise and manage problems thereby de-escalating a crisis,
- supporting people to access local services that help them maintain their physical and mental well-being, and
- Increasing the flexibility of service provision to fit in with patients' other commitments.

## **6.2 Early Intervention**

### **6.2.1 Extra Care Housing**

Ensuring an appropriate amount of Extra Care Housing according to need, is one of the key components to our vision. We are committed to continuing reductions in the use of institutional care, and will continue to ensure the provision of suitable housing and support for our older residents. For this we will need extra care housing in areas across North Somerset.

Extra Care housing is a concept and covers a range of models:

- It is about living at home and not in an institution.
- Purpose built Extra Care Housing involves constructing a number of accessible self contained flats / bungalows on a site that also has office and communal facilities that can be used by those living on site and the wider community.
- Extra Care is about building a community, including mixed tenures and mixed abilities, with units starting with a minimum specification of a one-bedroom flat upwards.
- Personal care services are provided within Extra Care Housing and are registered with CQC as domiciliary care services.
- Housing related support services are provided in an integrated package of support and care.
- Delivery of care is based on individual need and is flexible so that it can increase, or diminish as needed.
- The building and services are designed to encourage independent living with electronic assistive technology to that make independent living possible for people with physical or cognitive disabilities including dementia.
- Facilities are extensive and can be used for :
  - day care, ageing well and keeping fit,
  - provide floating support for people who live nearby who need a bit of help
  - a base for community teams of domiciliary care and health workers.

- Medical care and community nursing are brought in for individuals living in Extra Care, exactly as they would be in ordinary housing.
- The provision of meals is a usual feature of Extra Care Housing, however this is an optional service that an individual may choose to have or not on a daily basis.

There has been a major expansion of extra care provision for older people in North Somerset, in addition to the long established scheme in Worle, a new scheme (Waverley Court) recently opened in Portishead and a further large scheme in Sandford came into management in September 2009 as part of a 'care village' development to which the Council will have a number of nominations. In addition there are further plans for additional extra care in Worle with some specialist provision for people suffering from early onset of dementia.

There are further indications that some specialist extra care accommodation for younger people suffering from long term conditions including Multiple Sclerosis is needed.

Our biggest challenge with Extra Care housing is ensuring those that can benefit most from the services provided are aware of the schemes and are enabled to access them.

We also need to consider how the services that are provided within the schemes can be rolled out to benefit the local community

In addition we will establish a pilot extra care service that provides nursing care as a key component, referred to as extra, extra care.

### **6.2.2      *Telecare and Telehealth***

In line with national guidance, our aim is to make telecare integral to all community based packages of care and support. Telehealth and telecare will support the proactive case management of patients with long term conditions and will also enable patients to stay independent for longer.

We will increase the take up of telecare services in North Somerset to support independent living and create a Telecare and Equipment Centre for North Somerset to improve access and choice.

In North Somerset, Carelink provides a hub for telecare services which is available on a 24/7 basis. Plans are in place to develop a response services via contracts with existing care providers around the District to ensure that users of telecare services have round the clock access to care support as needed.

We will ensure any developments in Telecare and Telehealth are done in full consultation and cooperation between the PCT and the Council with a view to maximising benefits for people who may use the services.

NHS North Somerset has been investing time in the area of Telehealth, looking at potential opportunities together with the increasing amount of evidence emerging

from a variety of Telehealth pilots taking place across the country. Telehealth devices enable patients with a long term condition to self manage their condition in their own home, and any deterioration in condition can be detected early so that a hospital admission can be prevented.

NHS North Somerset are exploring ways to move forward in this arena, as this technology will allow us to progress into the future with innovative services while providing care closer to home for the population of North Somerset.

We are in discussions with NHS Bristol and NHS South Gloucestershire concerning proposals to create a new Telehealth service across the 3 primary care trusts. Before we move any further in this process however we are waiting to see the results from the NHS Cornwall and the Isles of Scilly Whole System Demonstrator Site. This will help to inform our next moves to ensure that we are making the right investment and accessing the patients that will most benefit from this technology. Investment in Telehealth is currently being discussed as part of NHS North Somerset's operational planning process. Proposals will have to demonstrate that it relieves pressure elsewhere in the healthcare system (e.g. by reducing hospital admissions)

### **6.2.3 Respite Care and Short Stay Breaks**

We will ensure that carers are supported by the provision of good quality, reliable, flexible breaks recognising that carers can have a life beyond their caring role and to support carers maintain their own health and well being and prevent carer breakdown.

Services offering a break to carers will work in partnership with the carer and person being cared for to deliver flexible and reliable services.

We will ensure a range of options are available to meet individual need, including short stay placements in residential care homes, if necessary. We will continue to develop short-term home based emergency respite cover to provide support in crisis or emergency situations.

### **6.2.4 Day Services**

We will develop day services that provide flexible, individually tailored services for people within their local communities; moving away from the traditional day care model.

All new contracts will include specific requirements in relation to delivering personalised services and we will work with providers to explore appropriate responses to meet the needs of people using personal budgets.

## **6.3 Urgent and Emergency Care**

The model for urgent and emergency care needs to ensure older people are assessed and treated in the right place by the most appropriate person and that service resources are used to maximum effect. Current services are relatively independent of each other and the expectation is a move to an integrated pathway with the different components delivered by a partnership that includes stakeholders

from primary care, secondary care, community care, social care, NHS Direct, Ambulance trusts and independent providers. The components comprise the Emergency Department; the GP led Health Centre, the GP in urgent care, the Assessment and Treatment Centre, and relevant community based services such as the rapid response and rehabilitation team.

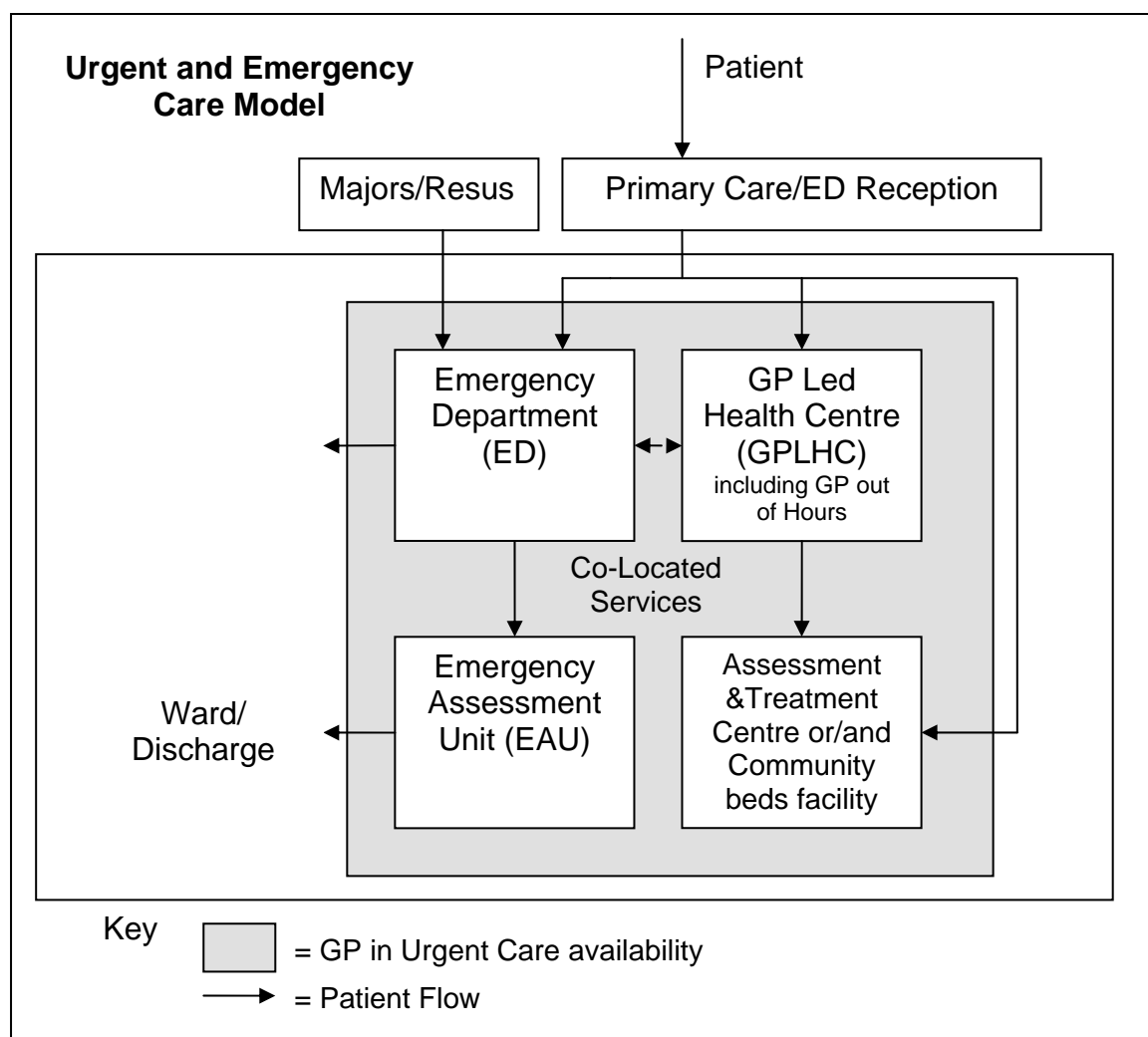
The model is designed to ensure:

1. Change is always to the benefit of patients
2. Change is clinically driven
3. Change is locally led
4. Patients, their carers and others will be involved
5. Patients will be the first to see and realise benefits

The urgent care model is based on the 'Demand Pyramid' where patients are given treatment in the most appropriate place, by the appropriate person. The aim of the model is to proactively manage demand and 'push' appropriate patients back down the pyramid. Thus the Emergency Department would focus on life threatening and traumatic situations where the time taken is critical. The other less complex cases will be dealt with by primary care through the GP Health Centre or community services where appropriate.

The urgent care model expects the co-location of majors /minors /diagnostics /Emergency Assessment Unit with the new equitable access centre (the GP Health Centre including the GP in Urgent Care) and Assessment and Treatment Centre (ATC - primary care access to diagnostics and assessment). The Emergency Department should have one integrated front door for patients, which includes a primary care front door.

The service model and patient flows are shown below:



### 6.3.1 Out of Hours

The Council's out of hours social work services are provided by the Emergency Duty Team (EDT) based in South Gloucestershire. Carelink (community alarm service) provides a 24/7 service and works closely with EDT, manages out of hours home care services and is the first point of contact for carers who have joined the Carers Emergency Response Scheme. It also provides out of hours logistical support to the District Nursing Service.

NHS North Somerset's Integrated Community Response Team forms part of the present integrated adult services programme and provides a 24/7 short term nursing response to crises in the community to prevent care home and hospital admissions.

We are investigating options to provide an out of hours response linked to the telecare service as listed above.

### 6.3.2 Rapid Response & Rehabilitation Service

NHS North Somerset has recently expanded the resources to rapid response and rehabilitation to include an additional nurse, physiotherapist and occupational

therapist, and new pharmacist, SLT, dietician and social work hours. The cost of expanding the team amounts to £319,000. The business case is based on releasing savings of £1.2 million in preventing admissions, readmissions and admissions to care homes, as well as reduction in care package complexity based on rehabilitation on discharge. We now need to embed working practice to ensure the team works in a fully integrated way.

The focus of the service is to rapidly respond providing intensive nursing assessment and support including short term packages of care and rehabilitation in people's own homes thereby avoiding admission and supporting earlier discharge. The aim is for packages of care not to exceed 14 days. The scope of the service also includes rapid access to home care for 14 days as well as night sitting services where required. The expanded service will work in two teams covering the north and south of the district.

We will monitor the impact this investment is having and how the service outcomes affect the requirements of a future rehabilitation team.

### **Falls Service**

The North Somerset Falls Prevention and Management service is run by a multi-disciplinary team within the Rapid Response and Rehabilitation Team. The Team works in partnership with many other agencies including Social Services, Health Promotion, North Somerset Housing, Care Connect and Great Western Ambulance Service and has strong links with the orthopaedic and osteoporosis services at Weston Area Health Trust.

The team has open access for people identified to have a high risk of falls and receives referrals from all partners. Interventions provided include supervised exercise training for strength and balance and a validated exercise programme delivered to individuals or groups. Training is provided for Care Home staff and residents and multiple partners are involved in identifying and supporting those at risk of falling. These include the Age Concern Community Development Workers who will undertake an environmental risk assessment of any older person's home when visiting as do Care and Repair, Housing and Supporting People staff. Avon Safe is a multi-agency accident prevention and safety promotion group which includes representatives from health and social care, the voluntary sector, the Police and the Fire Service from across the Avon area. Avon Safe promotes falls prevention and raise awareness of falls.

Falls prevention and management services link closely with fracture liaison and management, and bone health services in the acute trusts; and with primary prevention services that reduce the risk of falling for example physical activity. The aspiration of the PCT is to fully implement a falls and bone health pathway that spans primary and secondary prevention, and multi-factorial assessment and management. The Do Once and Share Falls Pathway has been identified as the model to implement.

### **6.3.3 Direct Access Diagnostics**

NHS North Somerset is committed to developing better direct access to diagnostic services for GPs, especially for MRI scans. Direct access by GPs allows them to manage patients more effectively, making a more informed diagnosis. It allows for the treatment of a greater number of patients in the primary care setting and at the same time a more appropriate referral to secondary care when it is needed. It will also have the effect of reducing referrals to secondary care for the purpose of obtaining a diagnostic test.

### **6.3.4 Emergency Care Practitioners (ECPs)**

NHS North Somerset have invested in ECPs which are highly trained ambulance paramedics who can treat people appropriately at home rather than see them admitted to hospital which can be a highly distressing and potentially counterproductive experience (such as exposing patients to viruses in hospital).

At the moment there is some pressure to meet targets on ambulance response times (8 minute response time for urgent calls) and some ECPs have had to be diverted into meeting these important targets. However, the long term strategy is to deploy them in avoiding unnecessary hospital admissions.

## **6.4 Access to Services**

### **6.4.1 Single Point of Access (SPA)**

The single point of access to community services comprises call handling, triage, signposting, information provision, assessment, service coordination and referral functions. "Care Connect" is our single contact point for people needing to access health and social care community services for adults. Call handlers will triage, signpost, provide information and commence a contact assessment. Cases requiring professional input are passed onto a team of professionals (sometimes called the back office) for a more detailed assessment. This team provides professional advice, information, and timely and coordinated services to meet complex needs. This enables us to provide an immediate response to some referrals from the first point of access. The SPA was established as part of our Partnership for Older People Project and is jointly commissioned by the PCT and Council to support the integration of community services. In future the SPA will support the coordination of end of life packages of care and be the point of contact through which patients coming to the end of their life can get hold of their key worker.

Care Connect make referrals to:

- Four integrated locality teams providing community health and social care services including Older Persons' Community Mental Health services (65+),
- Primary Care Occupational Therapy services (PCOT),
- Primary Care Domiciliary Physiotherapy services (PCPT),
- Disabled Adults Resource Team (DART),
- Rapid Response and Rehabilitation (RRR) - the newly integrated team consisting of Integrated Community Response Team and Intermediate Care Team.
- Specialist Community Health Services,
- Telecare Services.

To support integrated working and the seamless flow of referrals and information within and between teams there are plans to improve the information technology infrastructure. These plans include the commissioning of a new social care database (AIS) and customer records management system, which will provide better connectivity between different parts of the care management service, greatly improved functionality and a smooth interface with local NHS systems. The PCTs locally have commissioned a community services system RIO, which is being rolled out on a phased basis to health teams.

*Drafting note - Paragraph needed on how they will interface.*

Supporting People services are currently developing a single point of access including individualised self assessment options. This will be accessible for both potential service users and services providers and will link with Care Connect and the brokerage team.

#### **6.4.2 Single Assessment Process (SAP)**

Care Connect carries out initial screening assessments which are now developing into FACE contact assessments.

We are currently developing a single assessment tool that can incorporate the requirements of the personalisation agenda including outcome based care planning and resource allocation. This will be used by all health and social care professionals in North Somerset. An electronic version of the assessment will be embedded within the AIS database, and will be supported by the Practitioner Portal tool, designed to support remote working.

The overall aim of the SAP will be to ensure that we only need to collect information once but can use it many times and a process that allows for sharing of information between agencies.

We are focusing our work to improve the range of services available to people who fund their own care, including people who may not wish to be formally assessed and will improve access to social care assessment for people in hospital who may not in the past have been routinely referred for assessment.

#### **6.4.3 Self Assessment and Mediated Self Assessment**

As part of the single assessment developments outlined above, we are also planning to introduce the facility for individuals or people acting on their behalf to complete a self assessment, via the internet. The self assessment tool will be accessed through Care Connect pages on the council website and will allow individuals to directly and simply express their needs and requirements.

SPA staff will triage electronic referrals as a result of the self assessment.

Online self assessment will not be appropriate for everyone; SPA staff will also offer mediated self assessments over the phone, where appropriate.

This development will offer individuals the opportunity to access information and services from the comfort of home at a time that suits them.

#### **6.4.4 Brokerage**

We have introduced a 'Brokerage' service responsible for procuring domiciliary care packages, care home placements and day service resources in line with care management assessments, and continuing health care packages against assessed needs.

The brokerage team includes "care navigators" who specifically assist people responsible for funding their own care. This service is available irrespective of whether they wish to have a formal community care assessment (although they will be encouraged to have such an assessment or to self assess via the RAS).

We will develop the brokerage service over time to become one of the resources available to people who need assistance with the development of their personal support plan or who want our help in identifying particular care resources included in their support plan.

When fully implemented there will be a complete database of all services available in North Somerset including Voluntary Organisations and Day Care.

People wanting to find out what services are available and how to access them will contact Care Connect who will undertake an initial assessment and refer them on to the brokerage team if appropriate. Staff in the brokerage team will then help individuals decide what services they wish to purchase to best meet their needs.

To support the brokerage team, we have recently introduced the "Domiciliary Care Allocation Website" (DCAW). This introduces a new way by which care providers can see what work we wish to commission through the use of the website. Providers can log on to find out what packages of care are unallocated, rather than wait for us to call them.

#### **6.4.5 Personal Budgets & Health Budgets**

Individual and Personal budgets are already being used in social care and the number of older people using direct payments is increasing. A significant proportion of those involved in the roll out of Personal Budgets are older people and there are some good examples of these users being supported to plan their own services in creative and very individual ways.

We are keen to increase the numbers in receipt of Personal Budgets and are analysing ways to support this aim. We are following the developments being made nationally in Health Budgets with a view to introducing them in the future in North Somerset (legislative change will be necessary to allow the NHS to make direct payments to individuals); this will in effect, create a multitude of "individual commissioners" who will purchase their own services. Local community services will need to be responsive to the wishes and choices of these individuals. If they are

not flexible enough, they will find that budget holders will turn elsewhere, including non-NHS and private providers, for their support and care needs.

This gives us the opportunity to drive quality and develop services that meet individual needs, not just of individual budget holders but all service users. We will create seamless services for individuals by ensuring health and social care needs are viewed in tandem.

## **6.5 Community Based Managed Care**

Currently self care in NHS North Somerset is mainly supported by community staff such as Community Matrons, practice nurses and specialist nurses who focus on patients with complex long term conditions rather than the patients with low level health needs.

We have expanded our Community Matrons in response to findings from our benchmarking exercise. They have a target to deliver an additional 350 avoided admissions a year with this extra investment. Some of these admissions will require actions solely from the Matrons whilst others will involve the provision of more intensive rehabilitation services through the Rapid Response and Rehabilitation team.

### **6.5.1 Locality Teams**

Managers have been appointed to the new integrated Primary Care/Adult Social Services community teams as part of North Somerset's POPP project. Business process planning is taking place in order to combine processes, wherever possible.

Through integration, we aim to ensure that service users receive a single unified response from health and social care services in North Somerset, that access to services is improved and duplication of information and effort is eradicated ensuring that service users are not confronted with multiple assessments or requests for information.

### **6.5.2 Rehabilitation**

Rehabilitation is a process which starts with the assessment of impairment and leads the definition of specific, measurable rehabilitation goals which are reviewed and amended at key stages. This process is best carried out in the context of an interdisciplinary team, with the person and their family context at the centre of the goal planning process.

The quality and availability of Rehabilitation services are seen as a key factor in achieving our aim of ensuring a coordinated pathway to enable people to live as independently and safely as possible.

The following principles of rehabilitation are fundamental to rehabilitation services to be commissioned for older people by the PCT and the Council.

- Rehabilitation is a process which should start as soon after admission assessments have been completed and continue until and mostly beyond discharge,
- Rehabilitation services will be provided to patients so as to avoid their unnecessary admission to hospital care,
- Rehabilitation is necessary to restore daily living skills and mobility in people recovering from acute illness,
- Rehabilitation is essential to aid recovery from planned or emergency surgery (but may comprise self rehabilitation),
- Rehabilitation is an important, often essential, component of chronic disease management,
- Rehabilitation must include medical contribution to ensure treatable illness is not missed,
- Rehabilitation must be inter-disciplinary and evidence based, and will be delivered to achieve goals mutually agreed with the patient and carer/family,

We will ensure that the rehabilitation pathway is well defined to enable a seamless transfer of care between services and that timely, relevant treatment is provided by carrying out appropriate assessments and regular reviews.

Prior to discharge from hospital an appropriate package of care needs to be put into place. This work should start, as early as practically possible to ensure that community based rehabilitation can commence.

We will target rehabilitation services to support individuals who have realizable goals. For this reason where an individual is no longer making progress, we will discharge them from active rehabilitation and arrange an appropriate care package where required. Individuals may re-enter rehabilitation services if they are assessed to have realizable goals.

We already invest in domiciliary support on discharge through our joint rapid response and rehabilitation service. We also provide some residential based support (Clevedon Hospital and step down places). However, the rates of placement into care homes on discharge are very still high. We are therefore investigating ways to develop additional “step down” facilities that can be used to offer additional rehabilitation following a hospital stay or period of acute illness to enable people to return home. Consideration is being given to using vacant accommodation in existing Extra Care Housing and / or care homes.

Repairs and adaptations, however small, are often the key to enabling clients to remain living independently in their own homes, over the past 5 years we have experienced a substantial increase (60%) in demand for major adaptations using DFG money. Care & Repair help adapt and improve homes, provide support and sign posting to relevant services for older home owners and private tenants. We have recently been successful in securing funding to extend the Care and Repair service in North Somerset.

Care & Repair work in close liaison with Rapid Response and Rehabilitation and Supporting People floating support providers who identify people who can benefit from the Care & Repair service.

#### **6.5.4 Home Care**

Home care is a key service that enables older people to continue to be supported in their own homes. The council's in-house START team provides an initial short term re-ablement services for new service users and service users whose needs have significantly changed, they work closely with the rapid response and rehabilitation team and initial data evidences high levels of success in promoting independence. In addition to START, the independent sector provide any long term home care packages for people moving on from START.

Over the past five years, we have experienced a massive increase in the volumes of home care provided; this has lead from time to time, to some difficulties in sourcing sufficient home care to meet demand particularly in rural areas. Measures have been put in place to incentivise providers to increase levels of provision in areas where historically home care has been in short supply. In addition, we will work with providers to improve terms and conditions for Care Workers in North Somerset in order to improve retention and availability. We will continue to measure the effectiveness of these measures.

In order to address issues of availability, travel and to offer greater flexibility to work with more complex needs, providers will be guided to work in tighter geographical areas. We will divide the area into a number of zones and, using a framework agreement, will create smaller working partnerships between providers. The aim of this will be to positively impact recruitment and retention; providers will be able to target recruitment locally, offer work locally, reduce travelling time for care workers and encourage 'greener' ways of travelling i.e. walking and cycling.

Providers will be encouraged to work alongside local Voluntary and Community Organisations (3rd Sector) and the PCT. It is also hoped that relationships will form with local GP surgeries and pharmacies and possibly even care/residential homes.

A forum for each zone will be set up by the Providers with representation from Service Users, carers, local authority officers and members, the PCT and local 3rd Sector groups.

We will maximise the opportunities offered by the location of Extra Care Housing Schemes within the zones to secure both efficiencies and capacity to support vulnerable people 24/7.

#### **6.5.5 Acute Hospital Services**

The PCT commissions acute hospital inpatient, outpatient and diagnostic services from the 3 acute Trusts in Weston and Bristol. Older people consume a significant proportion of acute care services that may often not be the most appropriate form of care them. This arises because processes and lack of alternative services direct the flow of patients to acute hospitals. The Transforming Community Services Strategy will help redirect that flow as will the development of the urgent and emergency care

model (section 6.3).

Elective stays in hospital will be as short as possible and will involve active rehabilitation focused on getting people back on their feet as soon as possible. Discharge planning will commence as soon as someone is admitted to hospital.

### **6.5.6 Community Hospital Services**

Bristol Health Services Plan is a major reconfiguration programme designed to transform, modernise and improve acute and community-based health services in Bristol, North Somerset and South Gloucestershire. It includes both new and redesigned healthcare facilities such as the new Clevedon Hospital and new primary care resource centres in Portishead and Weston,

#### ***Clevedon Hospital***

We will undertake redevelopment work at Clevedon Hospital to maximise the opportunities for rehabilitation. The development is being considered in two phases.

- Phase One - An interim arrangement to maximise the use of the existing facilities including MIU, outpatients and beds.
- Phase Two - A long term model that considers the reprovision of the hospital either on its existing site or an alternative site in Clevedon.

We consider Clevedon Hospital to be pivotal to the success of the newly proposed rehabilitation pathway for North Somerset.

#### ***Community Resource Centre***

The Marina Health Care Centre at Portishead, provides a new facility from which rehabilitation can be delivered in terms of gym provision, group sessions, outpatient facilities and as a base for staff.

The Healthy Living Centre at Bourneville in Weston Super Mare provides all forms of primary care. There is a team of doctors and nurses serving the community providing general practice medical services including: doctor surgeries; nurse led minor illness clinics; treatment room clinics; clinics for diabetes, heart disease and respiratory disease; vaccination clinics; phlebotomy; antenatal clinic; health visitor clinic; counselling; support to stop smoking.

These facilities will link into the network of health shops identified above.

### **6.5.7 Nursing Care**

In general people who choose to enter care homes have a wide choice of care homes of good quality. We have in the past however, had concerns as to whether levels of provision for older people with mental health problems were sufficient to meet demand in the medium term. We have increased this area of provision with the introduction of a new 'state of the art' care home for older people with dementia near Nailsea (the Granary), the development by the St Monica Trust of a new care home with nursing in Sandford and the forthcoming development of the Ebdon Court site by Housing 21.

### **6.5.3 End of Life Care**

The phase “end of life” ends in death. Definition of its beginning is variable according to individual and professional perspectives. In some cases it may be the individual who first recognises its beginning. In other cases the principal factor may be the judgment of the health/social care professional /team responsible for the care of the individual. In all cases, subject to an individual’s consent, the beginning is marked by a comprehensive assessment of supportive and palliative care needs.

End of Life Care helps all those with advanced, progressive, incurable illness to live as well as possible until they die. It enables the supportive and palliative care needs of both the individual and family to be identified and met throughout the last phase of life and into bereavement. It includes management of pain and other symptoms and provision of psychological, social, spiritual and practical support.

In setting the scene the national End of Life Strategy, published in July 2008, describes end of life care as having had relatively low priority in health and social care services. The strategy’s aim is to bring a step change in access to high quality care for all people approaching the end of life, whatever the patients preferred setting and irrespective of age, gender, ethnicity, disability, religious belief, sexual orientation and diagnosis.

We will ensure that we deliver quality services and maximise choice for individuals in North Somerset through a model of care that includes:

- End of life care facilitation in primary care and care homes with the intention of providing practical support to implement and embed into everyday practice, the tools designed to identify people coming into their last 6 months of life. This includes advance care planning, applying Gold Standards Framework approaches, and use of a care pathway.
- An end of life register that captures individual’s preferred place of care.
- A palliative care framework that sets standards for staff by way of actions in response to managing care needs.
- Enhancing the single point of access to include coordination of services on behalf of clinical staff thereby releasing their time to hands on care.
- Improving the provision of information and advice to patients and their significant others through a dedicated web-site and literature as well as providing palliative advice to clinicians.
- Enhancing the skills of professionals supporting patients at the end of their lives through education opportunities, support from specialists.
- Development of an enhanced workforce to support more patients dying at home.
- Ensuring the local infrastructure is adequately resourced to support more people dying in the community e.g. community equipment.

## **SECTION 7            Infrastructure Issues**

To support the implementation of this strategy, we will work jointly to ensure the necessary infrastructure issues are in place as follows:

### **7.1        Workforce Development**

Our aim is to support the development of “a highly skilled, valued and accountable workforce drawn from all sections of the community. This trained and trusted workforce will provide imaginative and innovative services, looking at individuals in their personal, family and community context. Alongside carers and volunteers, the workforce will make a positive difference contributing to people’s health, happiness and well-being.”<sup>2</sup>

We also need to ensure that there are sufficient numbers of people with the right skills in the right place at the right time to both commission and provide the more individual and personalised services of the future.

Most training, both professional and in-house bespoke training is geared to meeting the training needs of the current provision. While much of this will be relevant for the future workforce there are new and additional skills the workforce will require in order to commission and provide a more personalised service.

We are working cooperatively to support the development of the adult social care workforce in the South West Region, focusing in North Somerset on the workforce implications of the declining usage of nursing homes.

Through consultation and business planning, we have agreed our strategic direction in relation to workforce development as follows:

- services that meet customer outcomes for social care and health
- development of self directed support, including personalised individual budgets and increasing the numbers of people receiving a direct payment
- facilitating increased choice and control for the individual purchase of services
- enhancing prevention through partnerships and building community capacity
- planning and commissioning services to meet the needs of the population
- reviewing and maintaining the social care market to respect the need for capacity, quality, safety and cost effectiveness.
- ensuring high quality and targeted services with a specific focus
- supporting social inclusion and well being

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<sup>2</sup> Options for Excellence – Building the Workforce of the Future  
October 2006

- Achieving the Local Government (LGA) equality standards to ensure that our workforce is reflective of our community.

We will commission training to support transformation as follows:

- Inter-agency rolling training programme for managers and staff to support the integration process for the locality teams.
- Business process changes and IT developments related to the SPA, and the Common Assessment Framework.
- Understanding and managing whole system changes being introduced with personal budgets and self directed support
- Change management training for managers and staff.

We will improve access to health and social care employment by:

- Continuing to support the modern apprentice scheme for social care, linking with Weston College to extend the scheme with the external providers, encouraging recruitment in the younger age group with and providing a qualification pathway, via NVQ 2 and 3.
- We will work in partnership with skills for care to encourage older workers to return to work.
- Providing Care Ambassadors to go into Schools to give presentations to year 9 students, encouraging them to consider a career in Social Care.
- Offering shadowing opportunities to students from local colleges and Schools.

We will help develop the provider sector by:

- Working with a range of providers to develop a series of improvements such as capacity building, localised working, development of new approaches to provision (e.g. Outcome based care provision).
- We are currently providing a substantial level of training in the voluntary and independent sector; we will continue to monitor qualification levels in the care agencies to ensure that they comply with national minimum standards. We will encourage all staff undertaking caring tasks to be trained to at least NVQ level 2
- Developing robust contracting arrangements to ensure quality provision.
- Focusing the work of Care Learning on those care homes assessed as either Amber or Red under the “Learning Exchange Network” project. This will assist with training plans to address staff development gaps to enable them to meet the required standards.

We will facilitate staff retention and ensure knowledgeable, experienced and high quality staff by:

- Continuing to progress the ‘grow your own’ approach, providing career pathways via vocational, professional and post-qualifying routes.
- Continuing to offer secondments for staff to gain professional qualifications.
- Offering Social Work Practice Learning placements, both in the statutory sectors and the Voluntary and independent sectors.
- Offering an in-house rolling training programme providing mandatory training and access to specialist training for staff as required and ensuring opportunities for staff to access the training are maximised.

## **7.2 Safeguarding**

We are committed to protecting vulnerable adults in North Somerset and have made a significant investment in raising the public profile of Safeguarding.

North Somerset Safeguarding Adults Partnership works closely with a range of statutory, independent and voluntary agencies to safeguard adults, particularly those more at risk of abuse or harm.

In North Somerset, the Council currently leads the provision of multi-agency workforce development and training for Safeguarding Adults. In 2007 a Safeguarding Adults Training Pathway was introduced to ensure that staff receive the appropriate level of training. Access to this training is provided to all statutory, private and third sector providers working in North Somerset. Training is comprehensive and take up of training by agencies and partners is monitored continuously to identify any areas where there may be a training deficit.

The Commissioning and Contracting services have a key role in ensuring that providers comply with requirements to inform and train staff about safeguarding responsibilities and the procedures for reporting and investigating safeguarding concerns. Contracts with care providers specify requirements in relation to safeguarding policy and practice including whistle blowing & a process for dealing with allegations of abuse that is fully compatible with N Somerset's Safeguarding policy. This also includes the production of information and guidance to their staff which must be consistent with the No Secrets policy and its attendant procedures.

The Contracts team includes staff dedicated to ensuring contract compliance, carrying out quality assurance checks and where necessary investigating complaints.

There is increasing awareness and recognition of safeguarding and adult abuse developed through training, the accessibility of local information and general awareness raising as follows:

- Leaflets are available in all buildings accessible to the public, including libraries, advice agencies, GP surgeries and police stations.

- a wide range of local events: the annual ‘Your North Somerset’ event at the BME Forum Annual General Meeting, at the annual ‘Ageing Safely’ event.
- ‘Community Cafes’ provide information and advice in a number of locations across North Somerset.

We have introduced a range of initiatives and service developments to contribute to reducing instances of abuse taking place, increasing recognition of the signs of abuse where it takes place and further improving the reporting of such incidents. These include:

- The development of a wide range of support services for carers, administered through Crossroads, to support carers in their role and to reduce the likelihood of abuse occurring because of a carer finding it difficult to cope with their role.
- A Conference on Elder Abuse, convened by Crossroads, aimed at carers and involving the Council’s Safeguarding Manager.
- An awareness campaign to engage GP’s and Care homes in the safeguarding agenda
- Improved support to users choosing to recruit their own support through a Personal Budget/Direct Payment, including awareness of and access to appropriate safeguarding checks (CRB, POVA list checks, etc) and risk assessment processes built into the support plan approval process
- Investment in preventive services for adults aimed at linking older people to local groups and services with a specific work stream for BME communities.

Improvements in the safeguarding database have enabled the safeguarding Team to improve recording of outcomes and demonstrate that in most instances, the investigation, planning and action taken concludes satisfactorily for the user and the carer.

We have a specific focus on engagement, through the North Somerset BME Forum, the Somerset Race Equality Council and through the involvement of users in the work of the Partnership board’s sub-groups with BME communities in North Somerset to raise awareness of Safeguarding services and levels of referral from these communities.

In order to ensure continual development of safeguarding we will:

- Deliver a rolling programme of training for GP’s will be implemented through GP forums in response to the low level of GP safeguarding referrals noted in the report.
- Develop processes for managing referrals and assessments in relation to the Deprivation of Liberty safeguards

- Promote the involvement of Independent Mental Capacity Advocates in safeguarding work
- Incorporate safeguarding processes into the development of services which are self-directed or commissioned directly by the user through the use of a Personal Budget.
- Improve guidance and training for staff of all agencies and continue monitoring the take-up and effectiveness of the training programme.
- Develop evaluation tools to assess user experience of the safeguarding processes.
- Ensure that information about the outcomes of investigations are made known to referrers (where appropriate).
- Ensure that work being undertaken as part of the Dignity in Care campaign has safeguarding issues at its heart.
- Ensure the Adult Integrated System (AIS) which enhances data sharing between health and social care has additional Safeguarding functionality.

The Transformation and Personalisation agenda brings the need for even more robust holistic risk assessment processes.

- We will deliver risk assessment training to meet all levels of need on an inter agency basis. Training will be defined by a clear focus on the basics of good practice, safety and protection are at the core of the training objectives and learning outcomes.
- The purpose of the Safeguarding Training at all levels is to ensure precise and timely assessments are made that lead to an outcome focussed plan that can be audited, reviewed, and evaluated within a the context of a well supervised workforce.

### **7.3 Dignity in Care**

In North Somerset our intention is to ensure dignity in care is extended to all adults receiving health and social care services irrespective of the setting and service provider.

Communication is a key component in fulfilling the Dignity Challenge; we will therefore ensure that expectations and standards are clearly set out in easy to read and understand publications. The Dignity Challenge states that high quality services that respect people's dignity should;

- Have a zero tolerance of all forms of abuse.
- Support people with the same respect you would want for yourself or a member of your family.
- Treat each person as an individual by offering a personalised service.

- Enable people to maintain the maximum possible level of independence, choice and control.
- Listen and support people to express their needs and wants.
- Respect people's right to privacy.
- Ensure people feel able to complain without fear of retribution.
- Engage with family members and carers as care partners.
- Assist people to maintain confidence and a positive self-esteem.
- Act to alleviate people's loneliness and isolation.

In order to maintain control and independence, people need information about what they are entitled to and what they can expect from services, and they need it at the right time.

## **7.4 Housing**

We understand that in order to achieve our objective of supporting people to remain independent in their community, we need to ensure that there is sufficient and fit for purpose accommodation in the community. This means not only ensuring the right supply of high quality extra care housing and sheltered accommodation but also to ensure good standards in general housing stock both in the private sector, owner occupied and in social housing.

We have 262 units of extra care housing in or about to come into management. We will investigate the need for further developments in this area with a view to managing demand on the capital grant made by the Local Authority to support such developments.

We are also aware that as more householders are enabled to remain in their own home, there will be an increasing demand for Disabled Facilities Grant (DFGs) to make adaptations to facilitate this. Demand has doubled since 2003, with the number of DFG improvements delivered rising from 132 in 2003/4 to 266 in 2008/9. We have made resources available by flexible use of the Housing Renewals investment pot, coupled with funding released through the Large Scale Voluntary transfer in February 2006, and responsive work of our Care and Repair Agency. Work is underway with a multi agency group to ensure that quality and efficiency of resources deliver the best outcome for people to meet their needs.

We have agreed a major adaptations strategic action plan to manage the increasing pressures on delivery of adaptations and are working with our Housing Association and health partners, maximising sources of funding and utilising new technologies.

We are focusing work on trying to get information and advice right so that older people can make informed housing choices in later life. We have recently redesigned the way people access housing options and advice services by introducing the new Housing Gateway which commenced in April 2009. This is a key component enabling people to gain access to information and services. We need to understand what will best meet the requirements of older people in relation to a housing options advice service and are working closely with Care & Repair England and the First Stop programme to this end.

We are committed to tackling fuel poverty and improving the thermal comfort of homes to reduce cold related incidents of ill health. The predicted rise in domestic fuel costs will require adequate support for older residents to heat their homes.

In addition older people living in the private rented sector or in non-traditional homes such as park homes will require specific services developed to meet their needs.

We understand that this strategy impacts our housing policy and we will work in close partnership with a range of housing providers to meet these strategic priorities.

## **7.5 Transport**

The Council has various proposals in relation to travel management and developments within the community strategy. They include proposals that encourage an improved and integrated transport network and allow for a wide choice of modes of transport as a means of access to jobs, homes, services and facilities will be encouraged and supported. The strategy aims to:

- enhance the facilities for pedestrians, including those with reduced mobility, and other users such as cyclists;
- deliver better local bus and rail services in partnership with operators;
- develop innovative and adaptable approaches to public transport in the rural areas of the district;
- improve road and personal safety and environmental conditions;
- reduce the adverse environmental impacts of transport;
- reduce congestion;
- improve connectivity within and between major towns both within and beyond North Somerset.

The council currently pays for and supports various bus routes across North Somerset. The majority are run on a commercial basis by local bus companies. However, some routes may not be profitable to operate at certain times such as in the evenings or at weekends because fewer people use them or there would be no bus service at all, such as some of the more rural villages. In order to improve the availability of these services, particularly for those who have no access to a vehicle, the Council directly funds the operation of additional services.

We will work with our partners to focus on the transport needs and requirements of older people, particularly in relation to rural areas supporting subsidised schemes, community transport and dial-a-ride schemes.

We will support the provision of community transport for those older and disabled people unable to access public transport by increasing the number of journeys on those schemes which are aided by the authority, in line with the Joint Local Transport Plan target.

The council is also committed to improving facilities at identified bus stops by raising kerbs for low floor buses, additional bus information cases and provision of bus shelters.

In addition the Council will continue to issue new diamond concessionary travel card passes which is a free bus pass for older people and residents with disabilities. This enables free travel on local buses anywhere in England between 9.30am and 11pm Monday to Friday and all day on weekends and bank holidays. For journeys commencing in North Somerset this scheme operates from the earlier time of 9am. We will explore the feasibility of using the diamond travel card on community transport.

We envisage that implementation of this strategy will reduce the need for patient and visitor transport across the district. We will continue to ensure that the limited patient transport service available is used appropriately and it is only used where there is a definite need for transport. NHS North Somerset spends over £5 million every year on ambulance and other transport services. Every day during 2008/09, over 100 journeys per day were cancelled on the day or aborted and we need to reduce these. We are therefore introducing new pilot procedures to overcome these and other issues to improve the patient experience.

The Great Western Ambulance (GWAS) NHS Trust was formed in 2006 is contracted to provide emergency and non-emergency ambulance and patient transport services across the old Avon area, Gloucestershire and Wiltshire (including Swindon). Gloucestershire Primary Care Trust is the lead commissioner of the service on behalf of NHS North Somerset.

Within the Bristol, South Gloucestershire and North Somerset PCTs, a network of procurement officers is being established, with the purpose of sharing expertise, processes and documentation to make the procurement process more efficient, and to ensure co-operation on procurements where practically possible collaborative procurements for all 3 PCTs, an example of which is the Patient Transport Service. This will be tendered for re-commissioning in September 2010, the lead is being taken by Bristol PCT and will be facilitated by a shared e-procurement technical solution.

## **7.6 Data Systems / Data Sharing**

We are committed to the procurement and implementation of the Northgate Adult Information System (AIS), which is critical to the delivery of the Personalisation Agenda. This will enable:

- Self-assessment online either over the internet at any time or mediated by a call centre.
- Immediate on-line calculation of an indicative Personal Budget. This will enable the individual to carry out their own Support Planning with family or professional assistance if required.

If professionals without access to AIS need input to the assessment then it can be passed into that person's operational system via the NHS Spine messaging service.

AIS will deliver Self Directed Support within the Personalisation agenda by enabling authorisations, financial management and accurate payments to clients and providers.

FACE has been adopted as the Single Assessment Process (SAP) tool to be used by the integrated teams and we have agreed information sharing protocols to facilitate data sharing in line with the Caldicott principles and with customer consent.

The Caldicott principles are as follows:

- The purpose for sharing information must be justified
- Do not use personally identifiable information unless it is absolutely necessary and where it is used, only the minimum personally identifiable information should be used.
- Access to personally identifiable information should be on a strict need to know basis.
- Everyone should be aware of their responsibilities.
- Everyone should understand and comply with the law.

## **7.7 Estates**

We are committed to maximising resources by achieving co-location of integrated teams as quickly as possible and are currently well advanced in securing property in Clevedon that will facilitate this aim.

## **7.8 Hospital Discharge Planning**

A key outcome in delivering the vision for this strategy is to ensure that hospital discharge is timely and safe. Getting Hospital Discharge right meets a number of joint objectives:

A strong discharge process will help ensure that patients are properly assessed to find the most appropriate post hospital provision. Getting this right can improve North Somerset's position on the number of service users placed in residential based services.

A timely discharge process can ensure that patients stay in hospital for the minimum period of time. This helps to maximise the throughput in hospitals and therefore the availability of beds to make more beds available for urgent and elective care.

A quality discharge process enables good patient care, ensuring that the right services are in place for the patient on discharge. This is good for patients and can help to minimise re-admissions to hospital.

We will ensure that those services that support good discharge arrangements such as Rapid Response and Rehabilitation, Interim beds, District Nursing services and services provided from Clevedon Hospital are adequately resourced and managed to facilitate a smooth discharge care pathway.

We will ensure that all staff in health and social care understand the discharge process and make timely referrals to appropriate services, where required. We will support patients and staff in making decisions around discharge to foster a culture that is not risk averse.

We will invest in resources to ensure that service users have maximum access to information so they can make informed decisions about their options after leaving hospital.

We will investigate new models of post hospital support as an alternative to people going directly into residential care.

## 7.9 Charging

Health care such as nursing, physiotherapy and occupational therapy is "free to all" at the point of access and as such, are not subject to charging procedures, whereas social care is subject to a variety of charging arrangements depending upon services received. For example, those receiving domiciliary care, day care and/ or Supporting People are financially assessed and depending upon individual circumstances are charged up to the maximum cost of providing that service. Those receiving respite care are charged at a flat rate up to 28 days then charging for residential accommodation guidance (CRAG) applies. Those living in care homes are allocated a fixed living expenses allowance (considerably lower than that allowed in community based services). Services required in personal budget support plans may not fall within current policy arrangements.

Our aim for social care is to move away from a charge calculation based on the services a person is receiving to one that ensures the same proportion of your care and support needs are paid for wherever you live.

However the results of the current DH consultation "Personal Care at Home: A Consultation on Proposals for Regulations and Guidance" on the proposal to provide free personal care for people living in their homes with the highest care needs will impact on the charging arrangements detailed here. The Personal Care at Home Bill 2009-10 will provide for those with the greatest care needs to be offered free personal care at home. Existing powers allow local authorities to provide certain community care services free of charge for up to six weeks. The Bill will remove this time limit in respect of personal care at home for those in the greatest need.

## 7.10 Risk Management

The Joint Commissioning Group has assessed risks associated with implementation of this joint commissioning strategy and has identified the following key risks:

- ***Population Growth & Impact of the current economic climate***  
50% increase in the over 65 population in North Somerset by 2025 and a 62% increase in the over 85s by the same year. The challenge to the service and the potential cost implications will be huge. The predicted increase of those with Dementia is also increasing which will have a huge impact on the need for intensive resources. The impact on funding streams over the next few years is not fully known at this stage. Obvious cost saving initiatives have been already been applied and further investment is needed to deliver additional longer term savings.

The strategy relies on joint financial contributions to various services from both the PCT and the LA, we will ensure that where necessary timely business case

proposal are submitted and systems are implemented to ensure recording and reporting of outcomes and associated savings and that these address the needs of both the PCT and LA.

- ***Competing Priorities between Health and Social Care***

Both organisations will be under increasing financial pressure which could result in conflict rather than cooperation resulting in lost opportunities for efficient working practices and joint approaches

- ***Market Management and increasing need for reliable community based care staff.***

Growth in the independent domiciliary care sector has risen by 8.9% in 2008/9 and 24% in 2007/8. This demand increase is presenting considerable supply side difficulties.

We have introduced an enhanced hourly rate we will monitor the impact of this increase and introduce the workforce and market development initiatives as listed in section 7.1 and section 8 to this strategy.

- ***Investment in community based services does not impact on current spend and puts at risk such developments modelled on invest to save principles.***

All staff working in the new services should be clear of their targets and able to produce information to demonstrate the financial benefits that the service is achieving.

- ***Diversion of Health funding to offer new treatments*** - The national Institute for Clinical Effectiveness (NICE) looks at the evidence of new treatments and technologies; if they are deemed to be effective, the PCT has to fund them within existing resources. These are often drugs but include all new treatments.

- ***New investment in community services such as extra care housing may encourage citizens who were otherwise managing without health and social care services to take up services.***

Those currently in receipt of services should be targeted where appropriate need has been identified, be given the information and assisted to access the new services where required.

- ***Impact of commissioning decisions have not been fully assessed***

For example the planned closure of Bristol General Hospital may impact on those needing community based services, maximising rehabilitation before placement in a care home will have an impact on PCT rehabilitation processes and resources. Lack of rehabilitation services will undermine the ability of other services to deliver improvements.

We will ensure that impact assessments (multi agency, as appropriate) will be built into the project plans of all service (re) design.

- ***Housing capital is not available to support the new developments that are needed to prevent people from having to move to a care home.***

Capital is needed to redevelop existing sheltered housing, develop additional extra care housing or assist with improvements and adaptations to help people stay in their own home.

Based on the results of the detailed needs analysis identified in 7.4 above, we will support bids to the HCA that are targeted at accommodation solutions for older people.

- ***Viability of Extra Care Housing*** - In response to the population composition in North Somerset, extra care housing is modelled on a percentage of sales to those selling their family home or who are responsible for paying for their own care. This market is largely untested in North Somerset and is subject to considerable competition from the leasehold market. This may jeopardise the capital financial modelling, making the schemes non viable

We will invest resources in undertaking a full market assessment to help us understand future aspirations better.

- ***Confusion over what new services are available, how they overlap, who does what and what we are aiming to achieve?***

There are so many changes on the horizon, all working to the same objectives the message of what is available and what their purpose is may be missed.

We will ensure that communication and publicity about new initiatives are co-ordinated, that information is clear and that front line staff are given the information to understand the strategic aims of this strategy.

## 7.11 Sustainability Issues

We have assessed that implementation of this strategy will have a positive impact on the environment. The driver is to deliver services closer to home allowing local employment and less travel requirements for those accessing services.

## 7.12 Equality Impact Assessment

Equality impact assessments have been carried out for the service areas covered in this strategy. It is noted that very few people from the BME population use our services. Census figures suggest that the number of people who are classified as 'other than white' has increased from 126 in 2001 to 137 in 2006. However, this data is now known to be out of date. The POPP project identified 49 people from BME population accessing services, this equates to 4.2% of cases which is higher than the anticipated local demographic.

Proportionally more women use the services than men when compared to the wider population of North Somerset. The estimated population in North Somerset over the age of 65 years, comprises 17,211 males and 20,964 females. This is roughly 46% males and 54% female population. The in house Domiciliary Care team quote, 88 (30%) male service users and 202 (70%) female, the contracts team show 392

(32%) Male & 848 (68%) Female, Self Directed Support service identifies 36% Male service users and 64% Female.

The services are designed to meet the needs of disabled people. Staff undertake disability awareness training and North Somerset Council uses the social model of disability when providing services.

Information on sexual orientation is not routinely collected, where care managers have identified specific needs relating to sexual orientation, this is identified in the care plan and services delivered according to the need.

The vast majority of service users are Christian (of various denominations), although there is a wide range of religions recorded.

38,876 people in North Somerset are estimated to be over 65 (2006 MYE). Of these 36% are between 75 and 84, 15% are over 85 and 49% are between 65 and 74. In a SWIFT report of those people over 65 using adult care services in 2007-08 16% are between 65 and 74, 39% are 75-84 and 39% are over 85.

The changes proposed are aimed at offering more options for people and are likely to make the service more accessible to individuals. Currently service users are generally required to move to a care home if they need daily support with living. The changes proposed should make service more accessible by offering a range of preventative services and more options to get better information and help through the maze of information of what is available.

Specific actions identified as a result of the assessment:

- **Race (Including Gypsy and Travellers)**  
Low take up - Ensure information about changes is accessible to minority groups.
- **Gender**  
Under representation of men using the service – this may be circumstantial or maybe that women are more likely to be living alone.
- **Disability**  
Information on changes will need to be provided in a range to media to ensure all people are able to access the information.
- **Sexual Orientation & Religion and Belief**  
Information is not collected and difficult the impact is difficult to assess without data. However, there is no adverse impact identified.
- **Age**  
Younger older people are not accessing adult care services. This is likely to be a reflection of need. However the focus on preventative services at an earlier age to prevent the need for more intensive services is likely to change this.

### 7.13 Engagement and Consultation

We are developing a joint engagement strategy across all the partnership to improve the evidence-base for the development of policies. Engagement and consultation will be streamlined to avoid duplication and replication.

Through the Community Development Workers and the new Community Agents, we will develop opportunities for older people to be involved in shaping services and to help in meeting identified needs. We will continue development of the Senior Community Link (SCL) and support SCL representation on the North Somerset Council older people's champions group to help shape services and monitor the older people's strategy.

We will ensure the creation of a user led organisation (ULO) in North Somerset in line with Department of Health (DH) ambition as set out in 'Improving the Life Chances of Disabled People'. The service will be developed in line with DH design criteria and modelled on existing Centres for Independent Living.

### 7.14 Age Discrimination

The Equality Bill currently before Parliament includes age provisions and seeks to:

- ban age discrimination against adults in the provision of services and exercise of public functions; and
- create a public sector duty to have due regard to the need to eliminate discrimination and to advance equality of opportunity and foster good relations between people who share a protected characteristic and people who do not share it. The duty applies to eight protected characteristics, one of which is age. The ban on age discrimination applies in relation to adults (people aged 18 or over), but the public sector duty applies in relation to people of all ages, including children.

The Equality Bill provides an unprecedented opportunity for the health and social care system to build on the progress already made, truly eliminate age discrimination and take further strides in ensuring care is personal and meets the needs of each individual and their carers regardless of age.

Ending age discrimination and promoting age equality are as much about changing the attitudes and behaviours of individuals and the culture and practices of organisations. Staff rarely set out to be ageist but for a range of reasons, their actions sometimes do not meet the needs of the patient or service user who is in front of them. This can be seen as simply poor service quality, although some age groups, especially older people, are much more likely to receive poor services. Importantly it means that the solutions to ending age discrimination and promoting age equality are the more effective design and implementation of existing policies and changes in the provision of services that especially the focus on the needs of the individual person set out in *High Quality Care for All* and *Putting People First* rather than the development of a range of new policy initiatives from government.

The health and social care partners in North Somerset will focus on ending age discrimination and promoting age equality through fairness in ensuring that services are provided on the basis of people's needs and personalised to them as individuals.

## **SECTION 8 Transforming the Provider Sector**

### **8.1 Using competition in healthcare**

Competition, or competitive tension, is one way of improving healthcare services. However it is not the only lever to do this and we will ensure good performance and contract management is the first approach adopted with an existing provider.

Competition is also a mechanism for increasing patient choice, which currently is limited to choice of location for elective surgery and those healthcare sectors where private providers are reasonably long-established, such as dentistry, care homes and mental health services.

We are undertaking a local healthcare market analysis in areas such as primary care services, the development of community services and public health commissioning.

We will take into account the following considerations:

- Is the market so small that it can only support one organisation operating efficiently?
- Will competition lead to fragmentation of services and possibly disjointed care for patients?
- How can we assess quality in preventative services?
- Comparison between providers will take into account the complexity of patient groups served.
- How can the PCT safely transfer risk to the provider, particularly where a service cannot be allowed to fail.

As commissioners we need to be aware of the characteristics of our markets and develop strategies for mitigating the above instances of market failure and ensuring the competition is effective. In the first place, we have to assess the risk that competition has/ will lead to market failure if one or more of the potential distortions above are substantial.

### **8.2 Building Capacity and Skills**

We recognise that the opportunities and requirements of the transformation agendas bring additional pressure on a sector that is already under pressure. We have introduced several new initiatives to help providers address these issues such as:

- Assistance to providers with recruitment and training.
- The expansion of the outcome based commissioning pilot with Care UK
- The expansion of Extra Care provision, using domiciliary care team aligned to these developments to work strategically in the local areas.
- The introduction of e-procurement processes
- The extension of the post code incentives
- Using incentive payments to reward achievements in efficiency, similar to those applied to the outcome based pilot noted above.

In addition we are working with domiciliary care providers to introduce formal zoning arrangement whereby North Somerset is divided into a number of zones and, utilising a Framework agreement, the creation of smaller working partnerships between providers to enable more joint working.

This initiative is based on the following principles:

- Problematic and complex packages will be shared to relieve pressures on individual care workers and providers.
- Packages requiring two care workers can be shared between providers, if necessary.
- Paperwork will be generic allowing for cross cover and subcontracting.
- Providers will work in an outcome focussed way with more flexibility and freedom in regards to the way the service is delivered. This also ties in with Personal Budgets.

Providers will be naturally guided to work in tighter geographical areas. This should have a positive impact on recruitment and retention. Providers will be able to target recruitment locally, offer work locally, reduce travelling time for care workers and encourage 'greener' ways of travelling i.e. walking and cycling.

Providers will be encouraged to work alongside local Voluntary and Community Organisations (3<sup>rd</sup> Sector) and the PCT. We are also aiming to build relationships between local providers and local GP surgeries, pharmacies and care/residential homes.

A forum for each zone will be set up by the Providers with representation from Service Users, carers, local authority officers and members, the PCT and local 3<sup>rd</sup> Sector groups.

This will:

- Enhance North Somerset Council's local knowledge of different services which will be beneficial when arranging and supporting Service Users with Personal Budgets.
- Enable better consultation with Service Users, carers and health care professionals when planning future services.
- Encourage and promote social capital and sustainable communities.
- Encourage Providers to think creatively when considering outcomes for Service Users. We will expect providers to maximise use of local resources/services and manage their care packages accordingly. If the Service User is no longer in need of home care or there is an alternative that would be more beneficial Providers must manage this accordingly in the Service Users best interest.

### **8.3 Developing the Third Sector**

We are considering various options to help develop the third sector, these include the following initiatives:

- Working strategically with Adult Learning to introduce a modern apprenticeship programme for care workers.
- Offer new care workers, via the Council Training Department, the basic skills as a pre induction course prior to being engaged as a care worker.
- Hold regular recruitment events with the providers.

Our aim is to make the provider sector as flexible as possible to be able to respond to individual needs in all locations within North Somerset. We will support the development of micro organisations to establish a network of support that can be accessed when needed.

We will develop a quality matrix that adequately measures key quality components and will ensure that we only commission services from service providers assessed as Excellent or Good quality providers.

#### **8.4 Managing the Redesign of the Care Home Sector**

Our commissioning policy has been to suspend the usage of homes that fall short of acceptable quality standards, whilst working vigorously with the provider, to improve the service. This initiative will continue.

We are aware that the changes encompassed within this strategy, when implemented, will see a reduction in the use of residential and nursing homes. We will therefore need to manage this surplus provision. We will communicate the likely impact of these changes to providers and will assist them in identifying opportunities to redesign services to meet the personalisation agenda. Providers will need to ensure their staff have the appropriate skills to embrace these changes.

We welcome approaches from providers who have proactively assessed their future development options and would like to work in partnership with us to transform their services.

#### **8.5 Joint Approach to commissioning**

Details of the changes to the wider strategic framework that have been introduced to manage the joint commissioning arrangements within North Somerset are shown in Section 11 (below). We are committed to maximising opportunities for joint commissioning as a way to:

- Improve health and social care outcomes for people in North Somerset
- Ensure integrated thinking and practice
- Ensure the most effective use of resources

**SECTION 9** Commissioning Intentions

Area	Actions	Cost Implication	Funding Source	Outcome
Prevention and Self Care				•
Early Intervention				•
Urgent & Emergency Care				
Access to Services				
Community Based Managed Care				
Infrastructure				•
Transforming the Provider Sector				•

To be completed by JCG following consultation using PCT OP plan and MTFF



## **SECTION 11            Governance Arrangements**

### **11.1   Transformation and Commissioning Board (TCB)**

At a strategic level, the ‘Transformation and Commissioning Board’ has been formed to agree and communicate a shared vision for the development and operation of social care and community health services in North Somerset, and to develop and implement joint approaches to the commissioning and delivery of services that improve social care and community health outcomes for the area.

The Board reports to the Health and Wellbeing Strategic Partnership (HWSP) which is one of the thematic partnerships within the North Somerset Partnership, responsible for overseeing implementation of the health and well-being chapter of the Sustainable Communities Strategy. The Board draws its authority from, and is responsible to:

- North Somerset Council for decisions in respect of social care and housing services and funding
- North Somerset NHS for decisions in respect of health services and funding.

The TCB also links to ‘Safer and Stronger Communities’ which is a partnership including North Somerset Council; Police; NHS North Somerset; Probation; Fire Services and the Voluntary Sector and has a remit of making services more accessible to vulnerable groups and increasing ‘social capital’

The TCB oversees the work of the ‘Self Directed Support and Personalisation Steering Group’.

The TCB has identified five key work streams emerging from the transformation agenda for health and social care, into which the various change projects and initiatives can be governed. The 2 strategic agendas that drive the work of the TCB are as follows:

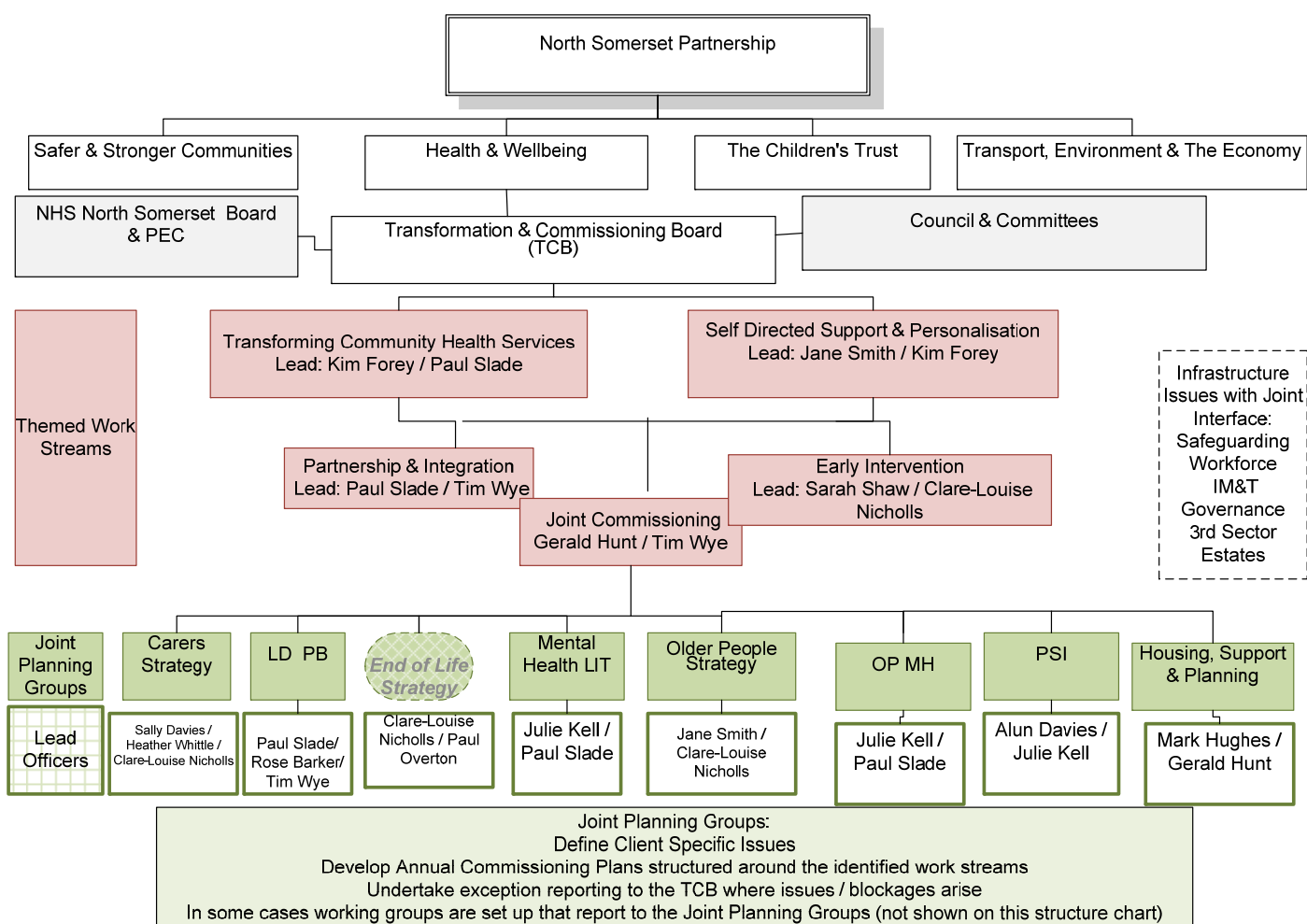
- Personalisation lead by North Somerset Council
- Transforming Community Services lead by NHS North Somerset

From these 2 agendas emerge the following important work streams:

- Partnership and Integration
- Early Intervention & Prevention
- Joint Commissioning

The following diagram shows the TCB in the context of the wider organisational decision making framework:

## TCB - Planning Framework



Supporting the TCB are the Joint Planning Groups (JPG) that have been set up to build partnerships in each strategy area. Their role in this structure is to contribute to delivery of the work streams.

Joint leads, one each from the PCT and the Council, have been appointed to take forward the work for each work stream.

This framework has been drawn up to bring the various change projects into a linked network, to clarify responsibility and to improve communication about developments.

### 11.2 Joint Planning Groups (JPG)

The JPGs will assist the TCB to move forward the work-strands identified. The JPGs also contribute to and in the longer term will be responsible for development of joint commissioning strategies in their area of interest.

The JPG offer a forum for all key stakeholders to meet and work together, they are also an invaluable source for engagement, involvement and consultation.

Each group has been allocated a lead officer from health and one from social care to ensure that there is engagement, ownership and or a response from within their

organisation for any decisions or recommendations made.

### **11.3 Joint Commissioning Group (JCG)**

The joint group has been set up as a quality assurance group supporting the TCB in managing the commissioning and contracting arrangements covered by the TCB, where interfaces exist. The JCG ensures that joint infrastructure issues are appropriately managed and to maximise the opportunities for joint work to achieve increased efficiencies and improved outcomes across community health and social care.

The JCG reports to Transformation and Commissioning Board (TCB) which in turn reports to the Health and Wellbeing Strategic Partnership (HWSP) as detailed in the diagram above.

The JCG is not a formal decision-making body, but has an important role in resolving interface issues, promoting partnership arrangements and in maximising joint working to reduce duplication and improve outcomes.

More specialist aspects of partner organisations (for example in health this would include NICE implementation of new drugs over which there is no local choice, very specialist interventions (e.g. ophthalmology, neuro-surgery, managing the GP contracts) are not included in the scope of the TCB or JCG.

The JCG performs the following role in relation to this strategy:

- To monitor joint contracts
- To manage the introduction of new projects that have a joint interface between NHS-NS & NSC
- To provide quality assurance for the joint commissioning strategy, taking direction from the JSNA.
- To monitor performance against identified targets in the joint commissioning strategies and to alert the TCB where targets are falling behind.
- To ensure consultation arrangements for joint commissioning strategies are robust, ensuring mechanisms for feedback are adequate, manageable and meaningful.
- To work cooperatively to manage joint accommodation and estates issues.
- To agree contracting arrangements with the 3<sup>rd</sup> sector for areas of joint involvement, particularly where there is investment from both organisations.
- To provide appropriate management information to adequately undertake the tasks identified.
- To advise on procurement processes and to be proactive in promoting opportunities to work more collaboratively.