

Best Value review of services to older people

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Appendix 1: The Review Process

The Review was carried out by a joint team from ACS, Health, District, voluntary sector, residential and home care providers. A 50 strong Reference Group, made up of individual users and carers as well as professionals from a very wide variety of local and national organisations provided external challenge.

- 1.1 **Challenge:** External challenge was provided by :
 - a a Reference Group of over 50 users/carers and professionals from a wide variety of local and national organisations (full list available on request) and who met at the start of the review to identify the key challenges facing users/carers and services for older people and at the end of the review to comment on the draft recommendations.
 - b The involvement of external organisations in the review team: Broxbourne District Council, SageCare, Quantum Care, Age Concern, South East Herts PCT, St Albans Hospital.
 - c The involvement of Penny Banks from the Kings Fund who reported her views on the scope, direction and outcome of the review directly to the Member Review Group overseeing the review.

- 1.2 **Consultation:** In addition to the consultation carried out through the Reference group the following:
 - a postal questionnaire survey of home care users & carers
 - b individual interviews with home care users and carers
 - c focus groups with older people organised through Age Concern
 - d presentations and questionnaire survey of ACS and selected Health staff
 - e focus groups with senior housing officers, hospital social workers
 - f presentations to PCT Boards

- 1.3 **Comparison::**
 - On the Whole Systems Approach (Beds., Buks., Essex, Luton, Leeds, Barnet, Kingston-upon-Thames)
 - On Information provision (Thanet and Huddersfield).
 - On Enabling Home Care (Leicestershire, Kensington, Westminster)
 - On Flexible Homecare (Leicester)
 - On Integrated teams (Sefton)

- 1.4 **Competition:** Much of the Residential Care, Home Care and Day Care provision for the elderly has already been externalised. Sage Care and Quantum Care, two key home care and residential care providers, and Age Concern have been closely involved in the carrying out of this review. The 3 out of the 5 recommendations of the review involve external providers in the delivery of

- 1.5 **Communication:** 4 Newsletters were produced during the course of the review to update stakeholders on progress and circulated to ACS staff and Community Groups.

Appendix 2: The Position Statement

1. Introduction

- 1.1 Hertfordshire has a population of approximately one million of whom 15% (approx. 156,000) are aged 65+
- 1.2 1 in 16 of people aged 65+ are receiving a service from Hertfordshire Adult Care Services mostly home care or residential care. Older people are also helped by voluntary organisations such as Age Concern, Alzheimers Society, Hertfordshire Action on Disability all of whom receive funding from Adult Care Services.
- 1.3 In Hertfordshire, Adult Care Services is working with partner organisations to improve services for older people within the context provided by the NHS Plan and the National Service Framework for Older People. The eight NSF standards are:
- ◆ rooting out age discrimination
 - ◆ person-centred care
 - ◆ intermediate care
 - ◆ general hospital care
 - ◆ care for people who suffer a stroke
 - ◆ care for people who are injured in a fall
 - ◆ mental ill health
 - ◆ promotion of health and an active life in old age
- 1.4 Adult Care Services aims to commission services that are flexible and responsive so that people can live as independently as possible and avoid inappropriate admission to hospital or a residential home. We aim to involve users and carers in the planning and monitoring of services, and to provide services that are sensitive to religious and cultural needs. We are monitored by the Department of Health through regular inspection, an annual position statement and a set of key performance indicators as set out by the Performance Assessment Framework

2. Demography

- 2.1 The number of older people in Hertfordshire aged 75+ is set to rise by 12% between 2000-2010, For those aged 85+, the increase is expected to be 20%. The rate at which the population is ageing in Hertfordshire is faster than the national rate.
- 2.2 Demographic trends suggest that in the future more older people will be living alone and less support may be available from family carers. The numbers of older people from black and ethnic minority groups will grow quickly as greater numbers in the "middle age" categories become older. These factors, taken together with increasing number of older people and longer life expectancy will have significant resource implications for Adult Care Services and the NHS in Hertfordshire.

3. Expenditure

- 3.1 The 2002/3 Adult Care Services budget for older people is approx. £73m. This includes funding provided to Voluntary Organisations and PCTs to provide services in partnership with Adult Care Services.

Of the total, the largest amount £40m is spent on residential and nursing home care. £19m is spent on Home Care, £3m on Day Care and approximately £6.3m on staff costs including Social Workers and Occupational Therapists.

4. Service Activity

4.1 Residential and Nursing Care

3,385 older people are currently being funded in residential and nursing care, 90% of whom are in homes inside the county. 56% of residents are aged 85+.

During 2001/2 1,238 placements were made into residential and nursing homes, 685 of which were direct from hospital, 429 from the community and 124 people were people whose funding had run out.

There are 157 homes with 6,394 residential nursing care beds for older people in Hertfordshire. The regular market analysis shows very high levels of occupancy. Places not purchased by Adult Care Services are bought by private payers or other local or health authorities.

Because of the high levels of occupancy, difficulties can arise in finding local and affordable homes. Adult Care Services aims to strengthen community based alternatives to residential and nursing home care to enable more older people to remain in their own homes for longer. We also plan to increase the number of beds available to offer greater choice to those who need this type of care.

4.2 Home Care

Adult Care Services arranges home care for 5,100 people aged 65+, amounting to 1.631 million hours per annum. 48% of home care clients are 85+. Approximately 80% of the hours are delivered by 17 home care organisations through block contracts.

In recent years, the service has become much more intensive and has been targeted on those in greatest need, particularly to respond to people being discharged from hospital. This has led to less older people receiving home care.

Adult Care Services plans to support more older people in their own homes by increasing the availability of home care and developing the service so that it can help people regain more of their independence. We also plan to offer more specialist care to older people with mental health problems. We will also be looking to strengthen the home support service offered by Voluntary Organisations.

4.3 *Day Care*

Adult Care Services arranges day care for approximately 1,400 older people. This is through in-house day care provision, or day care purchased from residential care providers Quantum Care and Runwood Homes. Additional day care provision is funded through Age Concern Hertfordshire.

The service has been targeted at those in greatest need and to support family carers. Following the Best Value Review of Service to People with a Physical Disability work is underway to expand the range of services offered at the day centre.

4.4 *Extra Care Housing*

Adult Care Services in partnership with District Councils and Housing Associations is planning to increase the availability of extra care housing in the county.

Extra Care Housing is an essential component of the spectrum of care services and can offer flexible support within a person's own home and delay or avoid the move to residential care. Adult Care Services plans to establish 60 new extra care places in 2002/3 and 400 places over the next 4 years.

4.5 *Intermediate Care*

Adult Care Services is working with Primary Care Trusts in Hertfordshire to develop intermediate care services in order to prevent unnecessary hospital admissions and to support people on discharge from hospital.

Intermediate care can help a person regain their independence and so remain at home for longer. A strategy for intermediate care is being developed in each Primary Care Trust and Adult Care Services have already contributed funding and staff to schemes in all parts of the county. These include additional intermediate care beds in Western House (Ware), Bulwer Lytton (Knebworth), and Felden Croft (Hemel Hempstead).

4.6 *Equipment*

In 2001/2 Adult Care Services provided 25,184 items of equipment to 7,029 clients. Plans to integrate the Health Equipment service with that provided by the County Council are currently out for consultation.

In addition a number of service improvements have been made to enable people to have easier access to equipment that will help them with everyday living. These include additional resources for bath equipment, specialist mattresses, and wheelchair trays. Other work is in progress in partnership with Hertfordshire Action on Disability, so that clients can be assessed at the Easier Living Exhibition to speed up response times.

4.7 *Voluntary Organisations*

Adult Care Services provides over £1m to Voluntary Organisations to support older people in the community through a range of preventative services such as day care, befriending, advocacy and respite care.

Additional resources for voluntary organisations have been agreed for 2003/4 to support more preventative services such as practical help inside/outside the home and culturally sensitive services.

4.8 *Carers*

In addition to services above Adult Care Services provides a range of specific services to support carers. Carer Co-ordinator posts have been established in each Area Team. Over £500k has been used to develop a range of respite services both through Crossroads and with other organisations which use volunteers. Age Concern and Alzheimers have both been funded to recruit carer support workers.

4.9 *Black and Ethnic Minority Older People.*

There are a number of resources in Hertfordshire to meet the needs of ethnic minority communities, eg an Italian residential and nursing home in South West Herts, a residential home - Minsden, in North Herts that offers day care and respite to Asian Elders, and there is also a Jewish Home. Adult Care Services arranges services in specialist provision outside the county in Barnet and Harrow.

There are also a number of community based voluntary organisations, some funded by Adult Care Services which provide services.

For example:

In Hemel Hempstead, Age Concern provide luncheon club facilities for Asian Elders two days per week.

In Watford and Three Rivers, Watford Asian community Care provide luncheon and respite services to Asian elders, and the Watford African Caribbean Association provides a similar service to African Caribbean elders.

In North Herts, the African Caribbean Lunch Club operate one day per week. In St Albans there is a similar club for Italians and Chinese elders.

Age Concern also provide a number of day facilities in North Herts and Broxbourne including an Italian link worker.

Population projections point to significant increases to the numbers of older people from black and ethnic minority communities. Adult Care Services plans to develop services, and increase its support to organisations who can develop services to meet the needs of these communities..

4.10 Meals on Wheels

The Meals on Wheels service in Hertfordshire is mainly provided by the ten District Councils. The level of provision varies considerably with some areas receiving a seven day service whereas in others the service can be five days a week or even less. Adult Care Services provide some meals at times when the main service is not available.

4.11 Transport

Adult Care Services provide transport to take clients to and from day centres. On a more strategic level, work is underway to deliver an integrated countywide transport service across the County Council and the Health Service.

4.12 Money Advice

The County Council's Money Advice Unit continues to operate a benefit outreach project to maximise attendance allowance and income support claims. In addition to individual work with clients, the project offers training and partnership working with other agencies. The total benefit gain from awards during 2001/2 was approximately £850,000.

5. Organisation

Older Peoples Services are managed within the Adult Care Services Department of the County Council. Reporting to the Director is the Assistant Director Older People and People with a Physical Disability who is responsible for the operational management of 7 Area Teams.

Each Area Team is responsible for assessment and care management and is made up of Occupational Therapy and Social Work staff, professional assistants, plus administrative and financial support.

Three of the Area Managers also manage a Hospital Social Work Team. We have five hospital social work teams based at the 4 in-county acute hospitals and one team based at Princess Alexandra Hospital in Harlow. Other Area Managers are responsible for the Sensory Disability and Emergency Duty teams

Appendix 3: The Scope of the Review

3.1 Key themes for the Best Value Review

The Best Value Review of services to older people aimed at improving the way Adult Care Services, together with its partners in the health & voluntary sectors, helped older people live as independently as possible for as long as possible, while ensuring best value for the people of Hertfordshire.

The Review looked at the range of transactions we have with our clients: from information giving & sign-posting, needs assessment, commissioning & care management and review, to the delivery of a range of services such as home care, day care, intermediate care, residential care, transport, housing, meals on wheels etc. In doing so it aimed to come up with practical proposals for meeting the following key challenges:

- Greater emphasis on **prevention** & stopping people entering crises,
- More emphasis on **enabling/re-enabling** people to become or remain independent,
- A more **flexible** approach to provision of services so that people have more choice & control,
- **Integrated** delivery of assessment & care management as well as care services,
- More **efficient and effective** services.

Since the challenges are not new, the Review has identified and built on existing work that is going on within ACS and beyond. The Recommendations therefore reflect the gaps that have been identified by the Review where significant further development work is needed to meet the change agenda of the department.

3.2 Work being undertaken outside the Best Value Review

Information & signposting: The “widening & deepening the Gateway” strand of the Simply Done Best Value Review has developed proposals for improving the quality of information on Infobase, involving community organisations in publicising & promoting the Gateway to improve access, and in changing the protocols on call handling so that more enquiries could be dealt with at the Customer Services Centre or Client Services without referral to Area teams and callers are given clearer explanation of what will happen next.

The development of Disability Resource Centres will significantly improve ACS capacity to inform advise and signpost people in relation to equipment, and the implications of

such a resource for services to older people will need to be explored. In the longer term, the current proposals for developing “one stop shops with many doors” in partnerships with District & Borough Councils, and the impact of the Libraries in the Community Best Value Review is likely to lead to significant improvements in the way we share & disseminate information with partners, as well as enhancing face-to-face access to information & services by the public.

There is scope, however, in this best value review, for looking at how existing providers of information, advice & sign-posting services, both specialists and generalists, telephone, face-to-face or web based, could be better linked, have common standards, and are accessible from the maximum number of access points (see Recommendation 4).

Assessment of needs: Work on developing a single assessment process with Health ready for implementation by April 2004 is well advanced. The Practice Development Programme is also underway and substantive work is expected in the near future in drawing together all the elements in this complex strand (process improvements such as direct referrals to providers, implementation of the Fair Access to Care, developing staff capability & capacity, IT infrastructure etc). In the shorter term, a common approach across all Areas to waiting list management is already producing significant reductions in the number of people waiting for initial assessments across all Areas. However, there is scope for looking at how the delivery of integrated assessment and care management across all Areas should be taken forward.

Commissioning services: Within the context of the work currently underway in developing the 3 year commissioning strategy there is scope for looking at how we could change the way we commission services to promote enablement/re-enablement (See Recommendation 1), and to give users and carers greater choice and control (See Recommendation 2).

Service delivery:

Home Care: A specialist Dementia home care service is being developed. There is scope for developing a rehabilitative focus to home care under appropriate circumstances. The possibility of developing lower level, preventative home help type services, as well as a rapid response generic worker type service to support hospital discharge could be explored. Greater choice and control to users and carers and greater flexibility for providers in allocating resources could be achieved by changing the way we commission services (see Recommendations 1 & 2).

Residential Care: Work on pooling budgets for residential and nursing care by March 2003 is underway, and as a result of the BVR of mental health for older people, work will shortly be starting to investigate any changes to residential care to meet the specialist needs of elderly with mental health problems. There is scope for a rehabilitative service to facilitate early discharge and prevent hospital admission in a residential setting (see Hypothesis 3).

Respite care: Work on finding flexible ways of supporting carers is underway, for instance a new booking system for carer provision in residential homes is being introduced, but there is scope for more flexibility and greater range of breaks for carers (see Recommendation 2).

Day Care: The physical & sensory disabilities review implementation team is taking forward proposals on developing specialist Disability Day Centres with access to a range of facilities, and also upgrading existing Multipurpose Day Centres. The new Commissioning Strategy will be addressing the development of Day Care provision for the elderly. (also see impact of Recommendation 2 on developing a flexible approach to Day Care)

Intermediate Care: West Quadrant is currently looking at a whole systems approach to intermediate care services with the aim of mapping existing provision and developing quadrant strategies on intermediate care. This work, to be completed by April 2003, will provide a basis for looking at how to improve, develop and co-ordinate intermediate care services in the 4 PCT areas (see Recommendation 4a).

Housing: Supporting people strategy, providing housing support services to a wide range of vulnerable people including the elderly is in place. The Supporting people team is embarking on a strategic planning exercise, mapping supply, assessing needs with the aim of commissioning & purchasing appropriate services. Extra Care sheltered housing has been set up in partnership with 2 District Councils, Housing associations and Home Care providers with the aim of creating 200 Extra Care places across the County over the next 2 years. There is scope for integrating this fully into the spectrum of care –particularly preventative services such as community alarm services (health care monitoring), well person clinics, exercise referral schemes (see Recommendation 4a).

Transport: The feasibility of a single transport service across Hertfordshire is being investigated by the Integrated Transport Partnership. Such a service would enable the public to have access to a centralised service that would provide information on transport services & entitlements (incl concessionary fares), book transport, help plan journeys, transport brokerage, and provide a specialist transport service.. There is scope for providing Direct payments for low level transport needs.

Meals on Wheels: The Meals on Wheels services provided by the borough and district councils are important to the overall provision of elderly people's services in the County. A joint review of Meals on Wheels service involving the 10 District and Borough and the County Council, is currently underway, led by Lynn Saville of North Herts District Council. The review is currently mapping existing provision, referral criteria and promotional arrangements. Close liaison is being maintained with this review to avoid unnecessary duplication and to integrate its findings & recommendations with this Best Value review.

Practical help: Fair Access to Care prohibits blanket policies aimed at excluding particular forms of support such as housework or shopping. There is continuing demand for more practical help being made available. ACS funding for the voluntary sector has already been configured to enable the voluntary sector to provide more practical, preventative help, such as Age Concern's handyman scheme. The revised Direct Payment scheme also enables clients to purchase a wider range of services to suit their needs. Nevertheless there is scope for giving clients a greater choice of the support they receive (see Recommendation 2).

Seamless services: There is scope for a more co-ordinated approach to service provision in each area so that users/carers can have access to similar

outcomes wherever in the County they live even if the configuration and distribution of services is different (see Hypothesis 4a)

Appendix 4: Details of Recommendations

RECOMMENDATION 1

To set up a one year pilot within the St Albans area, starting in July 2003, targeted at up to 50 users who have the potential and the motivation to improve and to regain their independence. Instead of “doing” things for clients, specially trained carers from the Sage Care Agency will work under the supervision of a trained therapist to help clients to improve (over a period of 6 weeks) their skills in everyday living tasks. The impact of the service on individual user satisfaction and dependency will be carefully monitored. The Pilot will cost an extra £60,000 to cover additional home care hours (1-1.5 hours extra per day per client) and a further £15,000 to cover the cost of additional training & support. However, it is expected that the Pilot will show that an enabling approach could reduce the cost of a person’s longer term care package. If successful, this scheme could be extended to all Areas in a phased way by April 2005.

Consultation with key stakeholders has made it clear that there is strong support and commitment from all sides to develop home care services in this direction, and meet national policy requirements around promoting independence. Furthermore, conditions are right to pilot this idea in the St Albans Area – there is commitment from staff & managers as well as good working links between Adult Care services, Community Rehabilitation Services and the Home Care provider – Sage Care. A one year pilot is planned to test this idea in practice, starting in July 2003.

The aim is use the home care service to help some older people maintain or regain their abilities to carry out everyday tasks about the home. For a number of years home care has been commissioned quite tightly in terms of tasks to be carried out, and the time needed for the home carer to undertake them.

Help has been provided with personal care and in some instances practical tasks. The assumption has been for the home carer to give this help or support, i.e. "to do it for the client". The client is seen as passive as someone who is "done to". This idea challenges that assumption, and sets out to provide a different type of service for some older people whom it is felt would benefit from home care service that was about helping them "to do things for themselves" and therefore become more independent.

The plan is to run a pilot project in the St Albans area. The project will involve specially home carers from Sage Care Agency working under the direction of an Adult Care Service or Community Rehabilitation Therapist to carry out an "enabling" home care service. The aim of the services is to help home care users regain independence by helping them improve their skills in everyday living tasks such as washing, dressing, housekeeping, cooking, feeding, and practical tasks around the home. The service will be targeted at users who have the potential to improve and the motivation to be part of the project.

Users would normally receive the service for up to twelve weeks. During the time, the home carers would meet the clients needs for home care and personal care - but would do this in a way which would help the client regain skills and abilities. The intention is that the service will lead to people having a better quality of life through being more independent and ultimately lead to a long term reduction in home care costs.

The proposal for a more “enabling” Home Care service will be tested through a one year pilot undertaken in the part of the St Albans area covered by Sage Care. The impact of the service on individual users in terms of satisfaction and dependency will be carefully monitored. The project will be overseen by a steering group which has representatives of the PCT, Community Rehabilitation Service, Adult Care Services and Sage Care. Although the primary focus of this idea is to deliver a more "enabling" home care service, we are also planning to undertake a review of "bed based" intermediate care schemes to see what evidence there is for their role in improving client independence. Evaluation material from a number of schemes across the County is to be analysed as part of the pilot, to enable a comparison between bed based and community projects.

Expected benefits to users/carers

1. Service users will be better able to carry out everyday living tasks. This will improve their quality of life and enable a person to remain in their own home longer.
2. Will help to delay or avoid the need for a person to move from their own home into residential care and to prevent hospital admission.
3. It should reduce the costs of a person's longer term care package, as the person will be better able to manage for themselves
4. Will encourage Adult Care staff to consider promotion of independence as part of the initial assessment and ongoing care package.

Outcome Measures

1. % of personal improvement goals achieved by clients
2. Improvements in dependency scale scores
3. Increase in client satisfaction
4. Long term reductions in home care costs

RECOMMENDATION 2

To set up a six month Pilot in the Welham Green and Brookmans Park areas, starting in May 2003, involving up to 19 Home Care users. The Pilot will test ways of making better use of commissioned hours over a 4 week period so that home carers can make more flexible use of the total hours commissioned. Carers would undertake agreed time critical tasks, such as toileting, but then leave and return later to help in a wider range of non time critical tasks, such as washing.. A handyman/woman will be employed by the Agency on a flexible basis to increase the range of help that the user could call upon. Additional time involved in preparing staff and potential service users will be contained within existing budgets. If successful, this scheme could be extended to all Areas in a phased way by April 2005

At present we generally commission packages of home care which are quite tightly prescribed at the outset in terms of tasks and time, even though an older person's needs fluctuate from day to day. One way of giving users real choice and control over the type of help they receive is through Direct Payments. However, many older people will either not want, or will be unable to take on the additional responsibilities entailed in Direct Payments, and will continue to prefer directly provided services. The proposal is to test whether it is possible to extend to other service users at least some of the increased freedoms enjoyed by people receiving Direct Payments through undertaking a six month pilot project in Welwyn Hatfield starting in May 2003.

The way this will be done will be to focus on defining the desired **outcomes** for the user and carer in the care plan, and then allowing greater flexibility in the way these outcomes can be achieved, within the overall 'cost-effectiveness' benchmark which also underlies the Direct Payment scheme.

The idea will be tested through a six month pilot scheme undertaken by Welwyn/Hatfield EPD team staff and local service providers in a particular locality within the team area. This team has been chosen because this Best Value pilot fits extremely well with a broader pilot of Practice Development that will also start in Welwyn/Hatfield in May 2003.

There is potential capacity in the home care system which could be used more effectively for a win-win result for users, carers, service providers and commissioners. The new approach could offer a way of easing some of the home care 'bottlenecks', where demand on the agency's service is heavily concentrated at certain times of day, and making more use of the currently wasted home carers 'down time' outside peak hours. The pilot service would also be able to call on the services of a 'handyman/woman', who would be employed by the agency on a flexible basis and integrated into the local home carer team.

The increased flexibility in the care plan would mean that users would have more choice and control on a day-to day basis over the way that their needs were met. For example, a man with poor eyesight may feel more energetic than usual one morning, and have managed to get up by himself. He doesn't need the usual assistance with shower and dressing that day, but would really appreciate some help with sorting out a huge pile of papers, bills and correspondence that he can't see well enough to tackle on his own. The home carer agrees to call back later in the day to help him with this task.

Users would not need to be rushed through all their morning routines in a single visit, as often happens now. There would be scope for carers to call in, check someone is alright and undertake any 'time-critical' task, but then leave and return later to give some assistance which is not 'time-critical'. It would make it easier for home carers to do extra 'pop in' visits to help someone who is unwell or generally feeling low on a particular day without having to check back for permission.

An added benefit of the Pilot- Achieving more Flexibility in Respite and Day Care

When we offer respite or day care, we are often able to offer only a limited range of options, which sometimes may not be acceptable and are therefore not taken up. The result is that the identified needs of the older person and their carer remain unmet.

Although the primary focus in the pilot is on delivering more flexible home care, care management staff in the pilot will be asked to use the same flexibility and 'outcome focussed' thinking in their care planning to meet other user and carer needs as well. Workers will be asked to identify each occasion when 'standard' day care and respite options are not suitable. They will receive project support to try to find individualised, cost-effective solutions, using all the flexibilities of the Carers' legislation and the new FACS framework.

At the end of the pilot, the aggregated information gained from users, carers and staff about the barriers to flexibility (both real and imaginary!) in day and respite care options will be evaluated and used to inform a further piece of work to see how these may be removed. In particular we are interested in exploring whether the use of a 'voucher' scheme for respite care is likely to work, and the scope for extending 'partial' Direct Payments for people to purchase parts of their care package even if they wish for another part (such as home care) to be provided through direct services.

Expected benefits to users/carers

- The increased flexibility in the Care plan would mean that users would have more choice and control on a day-to-day basis over the way that their needs are met.
- Users would not need to be rushed through their morning routine in a single visit as often happens now. There would be scope for carers to call in, check someone is alright and undertake any time critical tasks, but then leave and return later to give some assistance which is not "time critical".
- It would make it easier for home carers to do extra "pop in" visits to help someone who is unwell or generally low on a particular day without having to check back for permission..

Outcome measures

1. Comparing client satisfaction levels:
 - At the start and the finish of the Pilot
 - Between that of the Pilot and a control group
2. Feedback from care management and home care staff on benefits, drawbacks and feasibility of the Pilot
3. Actual cost of service delivered to pilot participants compared with cost of the service to the control group

RECOMMENDATION 3

To evaluate the effectiveness of existing ACS funded bed based intermediate care services in improving client independence so that the most effective approaches could be identified and adopted.

In 2003/03, the County Council spent £163,000 extra on Intermediate Care services (over and above the cost of residential/nursing care). These include Bulwer Lytton (residential home in Hatfield), Weston House (NHS unit in Ware) and High View (residential home in Dacorum). Each scheme has developed to meet the needs of its locality. There are different approaches to monitoring activities and demonstrating effectiveness. The Review has concluded that there is need for greater consistency in the way we monitor outcomes

RECOMMENDATION 4

a) Develop a common Countywide information strategy as part of the strengthening of Countywide partnership arrangements and establish a network of local ACS champions to drive forward the information agenda.

(b) Work with partners at a local level to ensure that

- **a core list of information items is available in key places which will help older people maintain their independence (particularly at times of crises)**
- **every partner commits themselves (through a local compact) to contribute to, as well as update, display or otherwise disseminate information and avoid duplication.**

(c) Build capacity among key agencies and staff from Health, District, Voluntary organisations who have contact with older people to identify those users who need to be referred on for an assessment or for more assistance finding and using the information.

Consultation with key stakeholders within ACS & voluntary agencies has led us to conclude that if users, carers and agency staff had clear information about where to go to access a wider range of services, and if this need was met through supporting voluntary organisations in providing information in a more structured way, then we would enable more people to live independently for longer or get timely help when they hit a crisis. In addition, more work is needed on ways of actively helping people access and use information once they have made the initial contact through a mini referral/casework approach.

Help needs to be available to identify information needs, access information and to use this information. Much of the information people are seeking is already available on the Herts. Direct web site and in our leaflets. The issues highlighted in the review mainly centre on the interface between people and this information.

There is a need to

- link with PCT information officers, voluntary organisations and GP practice managers to provide support for those receiving requests for information about our services in other organisations such as district/borough councils and GP surgeries. It is important to strengthen existing information systems in this way rather than introduce new ones.
- work with providers of IT equipment and training for older people to ensure this is available countywide and to promote its uptake.
- work with providers of day care, lunch clubs, mobile libraries etc. to increase the availability of IT equipment and internet access in these places.
- identify areas where information could be targeted at specific groups of people and at ways of achieving this e.g. through GP over 75 checks or following falls.
- ensure new staff receive induction in use of information systems.
- encourage voluntary organisations to include some form of quality assurance information (e.g. accreditation) when providing information on agencies involved in decorating, gardening, domestic cleaning etc

The following areas also need to be addressed:-

1. **Content of information.** There are gaps in the information on accredited agencies for small work, decorating, gardening, domestic cleaning etc. which are not all available county wide
2. **Format of the information.** The information is web based but can be provided in a number of formats eg. info. packs, individual leaflets, information sheets tailored to individual need etc. Work looking at the areas of duplication between this information and that held by other information providers is under way out of the PSD BVR.
3. **Assistance in identifying information needs** Assistance is already available through advocacy, Asian link workers and various information lines (Dish, Carers in Herts, HAD etc.). The issue for older people is how a similar model of assistance can be offered in the places they already go without requiring them to travel further. Consultation so far shows a wish for this assistance to be very local, carers in particular see their GP surgery as a first point of contact
4. **Assistance in accessing information** If the initial contact is with an organisation that needs to refer on, the originating organisation should offer to make the call/referral on behalf of the enquirer.
5. **Assistance in using information** There should be a named person to come back to if the information proves unsuitable, if further help is need or if the person wishes to be referred for an assessment. A theme throughout the discussions with users and carers was their desire for a face to face “client services type” system so they could move directly from information to making a referral with assistance.

Expected benefits to users/carers

1. Will help to improve the availability, usability, accuracy and reliability of information for users at those places where users prefer to go for information (Day centre organisers, wardens, carers, housing officers, GP practice managers)
2. Avoids people who ring one information provider being redirected to another unless additional expertise is needed.

3. Less frustrated users.
4. A gradual approach will enable us to focus on improving the availability of the most useful or critical information first.

Outcome measures

1. Greater user satisfaction with information provision (at first points of contact)
2. Less incidence of clients being sent from “pillar to post”

RECOMMENDATION 5

(a) Strengthen existing partnership arrangements between Health, County, District and the Voluntary sectors. (b) Develop joint protocols and processes with our partners in order to deliver single assessment, joint commissioning, integrated care management in an efficient and manageable way. (c) Decide at a local level, within a Countywide framework, how services could be directly commissioned by other agencies following assessment. (d) Enhance existing arrangements for engaging users/carers and staff in service planning and development

There is considerable evidence of joint working at frontline, management and strategic levels across Hertfordshire. However outcomes for service users, carers and frontline staff would be improved if Hertfordshire developed a whole systems approach to service delivery across the county. In the first instance this need not involve significant changes to current organisational and management arrangements. Priority should be given to developing a joint vision, a strategic approach to configuration of services, boosting existing joint planning arrangements, and the development of protocols for joint & integrated working at a local level. As these are being put in place, we can start work on looking at whether we have the right mix of skills and staffing to deliver our vision, and what (if any) changes need to be made to organisational and management arrangements.

Older people may need to be in contact with a wide range of statutory and voluntary organisations in order to improve their health and quality of life. A recent Audit Commission report “Integrated Services for Older People” stated that all too often older people receive a disjointed, confused response when they need help or advice. Frequently the responses that they receive meet their needs only in part. Services for older people must work together if they are to meet needs effectively and the ability to work across organisational boundaries is crucial. For service users it is essential that they receive the right service at the right time. If Hertfordshire is to have a truly integrated approach to health and social care for older people then we need to have a **whole systems approach** that is shared across all agencies and practised at all levels within each agency.

At a County level: The Hertfordshire Older People Steering Group will be asked to

- explicitly adopt a set of key principles and a “whole systems approach” which recognises that the action of one agency has an impact on that of all others,.
- Develop a shared vision of services to older people and implement any jointly agreed actions
- Review its own Membership to make it truly reflective of all agencies working with older people in Hertfordshire

- Ensure that the Workforce Confederation Generic Workers project delivers a training programme that supports the “whole systems approach”
- Identify joint resources to pursue the development of shared information systems as a matter of priority

At a quadrant level:

The two Quadrant Intermediate Steering Groups should ensure that this vision is reflected in the Intermediate Care and Local Delivery plans of each PCT. The Quadrant and each PCT should have a balance of services; available on a needs led basis with clear care pathways and referral routes which can be accessed easily.

Specifically the Quadrant Group should:-

- Identify areas of innovative practice
- Identify bottlenecks in service provision
- Identify gaps in service provision
- Evaluate all Intermediate Care and Capacity Building projects on an annual basis.
- Develop specialist quadrant based services e.g. Stroke Service, Falls Prevention Services
- Maintain a database of all Quadrant Intermediate Care schemes.

At a local level to have an joint implementation group with local partners which is able to implement jointly agreed actions from HOPSG and develop local initiatives e.g. single assessment process.

Also to give a local manager clear responsibility for moving this work forward and to release additional management time to enable them to do this.

Expected benefits to users/carers

1. Better outcomes for older people and their carers
2. Right services at the right time
3. More responsive service for black and minority ethnic elders
4. All needs addressed and assistance with negotiating the range of appropriate support
5. End of duplication and repetition in assessment process
6. Increased access to services across agency boundaries/improved service delivery
7. Increased independence for older people through preventative work with the Voluntary Sector.

Outcome measures

For Recommendation 5a

1. Number of jointly resourced initiatives coming out of HOPSG,
2. Establishment of specialist quadrant services to meet NSF targets
3. Increase in the number of joint initiatives at local level
4. Increase in the numbers of local services to meet local needs, particularly for “hard to reach” older people
5. Reduction in the number of older people whose discharge from hospital is delayed

For Recommendation 5b

Increase in number of joint processes and protocols developed with partners

For Recommendation 5c

Number of Health services being commissioned by ACS staff and vice versa

For Recommendation 5d

1. Number of joint local consultation processes/events held with partners
2. Number and type of consultation with users/carers

Appendix 5: Implementation Plan

Rec	Recommendation	Key milestones	Deadline	Reporting responsibility	
1	To test through a Pilot project the feasibility of providing an “enabling” Home Care service where home care users will be assisted in regaining their independence by improving their ability to carry out everyday tasks.	1	Consultation & preparation completed	June 2003	Peter Ruane
		2	Launch of the pilot	July 2003	ditto
		3	Interim report of the Pilot	November 2003	ditto
		4	Final report of the pilot	June 2004	ditto
		5	(if Pilot is successful) scheme extended Countywide	March 2005	ditto
2	To test through a Pilot project the feasibility of giving current home care users more choice and control over the type and timing of the services they receive while remaining within existing budgets	1	Staff, users & carers briefed	April 2003	Fiona Matthews
		2	Benchmarking exercise completed	May 2003	ditto
		3	Mid point review completed	August 2003	ditto
		4	Final report with recommendations	January 2004	ditto
		5	(if Pilot is successful) scheme extended Countywide	March 2005	ditto
3	To evaluate the effectiveness of existing ACS funded bed-based intermediate care services in improving client independence so that the most effective approaches could be identified and adopted	1	Evaluation tool developed	July 2003	Peter Ruane
		2	Participating IC schemes finalised	July 2003	ditto
		3	Consultation & preparation for evaluation completed	September 2003	ditto
		4	Evaluation underway	October 2003	ditto
		5	Final report with recommendations published	March 2004	ditto
4a	To develop a common Countywide information strategy as part of the strengthening of Countywide partnership arrangements and establish a network of local ACS champions to drive forward the information agenda.	1	Recommendation adopted by HOPSG	May 2003	David Robinson
		2	Countywide information strategy ready	October 2003	ditto
		3	Local ACS Champions identified	October 2003	Area Managers
		4	First meeting of Champions Network	November 2003	David Robinson

Rec	Recommendation	Key milestones	Deadline	Reporting responsibility	
4b	<p>To work with partners at a local level to ensure that</p> <ul style="list-style-type: none"> ▪ a core list of information items is available in key places which will help older people maintain their independence (particularly at times of crises) ▪ every partner commits themselves to contributing to, as well as updating, displaying or otherwise disseminating information and avoid duplication 	1	Approach to local information agreed in each Area with partners	July 2003	Area Managers
		2	Core Information items identified	September 2003	ditto
		3	Compact on Local information agreed between partners	December 2003	ditto
		4	Core information items published & disseminated in all Areas	January 2004	ditto
		5	First update of core information list published & circulated in each Area	June 2004	ditto
4c	To build the capability of key agencies and staff from Health, District, Voluntary sectors who have contact with older people to identify those users who need to be referred on for an assessment or for more assistance finding and using the information		Report on applicability of Age concern's awareness raising initiative	September 2003	Marion Birch
			Approach to building the capacity of local agencies on information and sign-posting agreed	December 2003	Area manager
			Evaluation of new Grants scheme to develop IT skills among older people	September 2003	David Robinson

Rec	Recommendation	Key milestones	Deadline	Reporting responsibility
5a	To strengthen existing partnership arrangements between Health, County, District and the Voluntary sectors	1 Key principles, shared vision, and revised membership agreed by HOPSG	July 2003	David Robinson
		2 Interagency Training programme to support whole systems approach put in place	March 2004	ditto
		3 Joint resources to pursue the development of shared information systems identified by HOPSG	October 2003	Ditto + Vince McCabe
		4 Each Quadrant Group presents a report to HOPSG on: areas of good practice, bottlenecks and gaps in service provision	September 2003	ditto
		5 Each Quadrant Groups presents its first evaluation of Intermediate Care & Capacity Building projects to HOPSG		
		6 Each Quadrant Group presents a plan for developing specialist Quadrant based services to HOPSG	December 2003	ditto
		7 Database set up of all Quadrant Intermediate care schemes	August 2003	DR + Ivor Cawthorn
		8 Joint Implementation Group set up at area level in all Areas	July 2003	Area Managers
		9 Additional management time identified to take forward work on local initiatives	July- Sept 2003	Area Managers
5b	To develop joint protocols and processes with our partners in order to deliver single assessment, joint commissioning, integrated care management in an efficient and manageable way	Joint workshops held in each locality on developing common understanding	Commence Sept 2003	David Robinson/ Adrian Smith
		Joint training programme in place at local level	Sept 2003	”
		Protocols and processes for delivering joint assessments in place	April 2004	”
		Protocols and processes for delivering joint commissioning in place	April 2004	”
		Protocols and processes for delivering integrated care management in place	April 2004	”

Rec	Recommendation	Key milestones	Deadline	Reporting responsibility
5c	To decide at a local level, within a Countywide framework, how services could be directly commissioned following assessment	Existing home care commissioning and home finding arrangements strengthened	January 2004	Area Managers
		Protocols on what Health resources can be commissioned by CS staff agreed	March 2004	Area Managers
5d	To enhance existing arrangements for engaging users/carers and staff in service planning and development	Existing ACS, Health and District consultation arrangements identified	March 2005	Area Managers
		An joint approach to consultation agreed	June 2005	Area Managers

