



B&NES Older People's Network Meeting

24 January 2008

Attended: Pam Richards, B&NES Council; Corinne Edwards, B&NES PCT; Allan Trinder, The Care Network; Pauline Swaby-Wallace, Bath Ethnic Minority and Senior Citizens Association; Janet Dabbs, Age Concern - Bath & NES; David Donaldson, Care and Repair B&NES; Dani Bown, Bath Mind; Joan Travis, Action For Pensioners; Mr & Mrs Bowles, Action For Pensioners; Hilary Elms, Action For Pensioners; Paul Thomas, Min PPI; Stephanie Taylor, WRVS; Jill Jones, Dorothy House, Hospicecare; Sarah Howard, West of England Centre for Inclusive Living (WECIL); Samantha Baldwin, ICAS; Sue Grimes, ICAS; Nancy Young, PPI RNHRD; Mary and John Walden, Action For Pensioners; Mike Woodhouse, Action For Pensioners; Beatrice Mary Bruce, Action for Pensioners; John Thackwell, Action For Pensioners; Sue Sherrin, Bath Mind; Cheryl Thomas, Care Network, The; Veronica Parker PPI - Bath; Diana Hall, PPI- Bath; Helen Storey, Crossroads - Caring for Carers B&NES; Pat West, PPI- Bath; Jetta Found, PPI- Bath; Joan Bird, Residents Association; Ronnie Wright, The Care Forum; Katharine Gonzales, The Care Forum (note-taker)

Apologies: Clare Core, Citizens Advice Bureau - Bath & District; Mary Ivey, Action For Pensioners; Lufkin Skeet, Action For Pensioners; Myra Dow, St John's Hospital & Bath Municipal Charities; Nina Fry, Arthritis Care; Liz Callaway, St John's Hospital & Bath Municipal Charities; Tracey Phillips, Bath Mind; David and Becky Yeodal, Action For Pensioners

Presentation by Corinne Edwards, B&NES PCT – Assistant Director of Service Improvement for Older People, Long Term Conditions & Urgent Care and Stella Doble, Joint Community Teams for Health and Social Care

http://www.thecareforum.org/publication_uploads/24.01.08%20Joint%20Community%20Teams.pdf

Corinne confirmed that nine community matrons had been appointed and will be in post by the end of March and the timescale for joint community teams being implemented is by October 2008. There is a stakeholder group around community teams to provide feedback for the proposed models. The stakeholder group met in January and will be meeting again in February and March. Action for Pensioners and The Care Network were amongst the organisations represented at the January meeting. If anyone else would like to be involved, please contact

Corinne. The aim is for a decision to have been reached about the preferred model by the third meeting. Staff are also being consulted.

Stella explained that they are looking at three localities with the same structure as children's services: Bath, Keynsham area and Midsomer Norton area. The divisions are not co-terminus with wards. Stella stated that it would be helpful to receive feedback on how they balance urgent care (the type of service where immediate same day response is required) and planned care (ongoing support provided).

Q: Does urgent refer to the rapid response team?

A: Yes, including weekends.

A selection of services that fit into both categories were shown in the presentation. NB CHC = continuing health care. OOH = out of hours. There are two proposed options and Stella welcomed feedback on which would be the best model.

Questions about the models:

Q: Option 1 appears more realistic, for example, RUH is in one locality. It would be better if knowledge to be spread goes to a single team. How are you holding information?

A: How we hold information is very important. It's important that health and social services IT systems communicate.

Q: The size of population and geographical distribution are similar considerations. It is very helpful to have three locations, but when planning there needs to be weighting to geographical distribution. With the evolution of LINKs, the PCT and hospital trusts have had a mechanism for public monitoring performance nearer delivery than the local authority has. Is the intention with the stakeholder feedback system to carry that group forward? Will a formal arrangement be developed with LINKs?

A: We will be looking at an on-going process as LINKs unfolds. The stakeholder group has a specific remit.

Q: The stakeholder group will have a legacy. Is there an action plan?

A: The remit at the moment is to focus on emerging models.

Q: There is a resource issue for the two models.

A: There may be a resource implication in terms of how we respond quickly in the three localities. Whether there will be enough capacity will have to be considered. We don't want one area not to be able to respond as quickly as the others.

Q: Will there be a cross over in locality provision? Could they borrow from other localities?

A: I'm sure if there are special circumstances, but not on a day to day basis. There will be flexibility if, for example, there were a flu pandemic in one of the localities.

Q: I'd like to see flexibility between teams, if there was a sudden surge, built in. I don't need an answer, but I'd like to see more flesh on the bones.

A: From the commissioning perspective, we also need to build in flexibility. As the models become clearer, the funding will be clearer.

Pam: The new domiciliary care contracts are based on four areas. Within them, there will be preferred providers. They will have a partnership working model to manage peaks and troughs. This should be written in (it has been written in for domiciliary care).

**Pam Richards, Strategic Planning Manager, B&NES Council
Delivering Outcomes Focussed Services (Home Care)**

Pam stated that Action for Pensioners, The Care Forum and other organisations had helped them to develop their outcomes and that they had also engaged with the Disability Equality Forum. The aim had been to establish the kind of outcomes that service users and carers would like to have in place. The service user and carer panel interviewed 15 potential providers for delivering the contract. There had been a feedback session the previous week, where the view was that being on the panel had been a very positive experience.

Mike Woodhouse, one of the panel members, agreed, adding that it had been a good exercise to meet people like Nancy and Ian, and that it was important that people get involved.

Pam stated that the representation had been broad and included people who were carers, people with direct experience of the process and people with learning difficulties, all of whom were able to ask pertinent questions. The feedback from the providers was that the experience had been challenging and helpful and had been very professionally done. The local authority had found the feedback to be very helpful. The scoring has gone into the overall evaluation process.

Ronnie: There was very positive feedback from the service users and carer panel. I hope to give feedback on what we could do next time. One of the key things was that the system was flexible and very clear. There were 15 interviews of approximately 45 minutes each. There are still some panel members that Ronnie will be speaking to, she will then put forward recommendations, so that the system can become common practice in the future.

Q: There was one panel member who did 14 interviews which provided a degree of consistency.

Pam: It was a heavy commitment, which was hard work and done on a voluntary basis.

Q: Were churches involved?

Pam: I think we are talking at cross purposes. We wanted to engage people with experience of our services. The process was about providers for independent care and was focussed on users or potential users of domiciliary care services. We were interviewing providers and church organisations were not bidding.

We hope that by early February we will announce who the preferred providers are. We are going through an evaluation process and hope there will be an announcement in early February. The next step is to engage with the same group. They will come together to devise ways in which users can help us to monitor the performance of new providers in terms of outcomes they deliver. We need to make sure that when they get the service that there is a very clear outcome. We are moving towards something which is not so specifically task focussed, for example, not about someone coming in to clean twice a week, but about having half an hour of someone's time, which will be more flexible. We need to devise a monitoring system, but it is not easy to measure outcomes. We have looked at evidence and practice elsewhere and now need users to get involved in a simple, effective way. We'll be working with the providers so we can devise a system that works for everybody. Service users will have a more effective way of indicating their concerns. We will still have a system for formal complaints. It would be helpful if anyone has any ideas, we will report back. We are very grateful for the commitment shown by all participants so far.

Q: There are national care standards - are inspection reports being considered?

A: We are anxious not to overload users with monitoring systems, for example, most providers have their own quality assurance. Where possible, we need to integrate with other systems.

Q: Most vulnerable users can't always express their feelings. How will that be monitored?

A: The outcomes approach will include talking to people face to face at reviews. Users have said they'd like a helpline for them or their family to use. In the first instance, they would go to the provider, but if the problem persists, there will be a short route to resolve the issue. We're talking about broader issues of satisfaction. We need to sort out contractual issues with this broader idea of looking at how effective the service is at helping the person to have a better life. This is a more flexible service which will be more difficult to monitor.

Q: Was there a representative of carers on the panel?

A: Yes.

Ronnie: This is an ongoing process and we'll ensure that you are updated.

There is a conference on 21 February from 10.30 am to 3pm at The Guildhall providing an opportunity to talk on a wide range of housing issues.

The next stakeholder meeting for community teams is on 26 February. If you would like to add your name to the list, please contact Pam Richards.

Putting People First

Pam: There is a new Government Concordat: Putting People First. This is about transforming adult social care. Agencies are joining up to improve the programme to respond to changing needs and it is not just about older people. B&NES has been a pilot for giving people individual budgets and it has been very successful for users. It is, however, challenging to make it work. People have had their needs assessed, and then they work out how they want their care to be delivered. The government wants this to be the new model. B&NES is slowly rolling it out to all clients.

Q: When will it be fully up and running?

A: There is no deadline, but this is a three year programme.

Q: Is it means tested?

A: The service is. You have to be eligible for the service.

Q: Did the Government wait until the end of the pilot to do a full evaluation?

A: No, but there is quite a lot of evidence. There will be a final report in April. There are lots of indications of what has worked well and what the cost implications are. The challenges have been highlighted.

Q: Is it indicating that it is saving money?

A: At the moment, the costs are largely neutral. The problem with cost projections is that there are variables and we are changing the way we are commissioning.

Q: Over the last three months, there have been problems with the waiting time for assessments/care packages. This is a concern.

A: In locality teams, they have not had problems. It is only in mental health they have had some problems with waiting times. The target is to start assessments in 48 hours for locality teams.

Q: The report to the overview and scrutiny committee detailing waiting times therefore only applies to mental health not to older people?

A: We don't hit the target 100% so we do prioritise. Very few people are kept waiting.

Q: Does the red light for exceptional wait for care not apply to older people?

A: It refers to the whole service and rarely affects people's care. Urgent cases are prioritised and some waits are for equipment. However, we are not complacent.

Q: How do Individual Budgets differ from Direct Payments?

A: The crucial difference with individual budgets is that the money is allocated up front for someone's support. They then decide what services they want. The service is delivered in any way the person wants. They will get involved in the determination of how the money is spent and will have a range of choices. As part of this they may want to have a direct payment, or take the money to an agency or commission a service. Direct payments will therefore remain a part of this process.

The transformation programme of Putting People First will involve closer working with the NHS and is about a preventative agenda. It is about looking at the wider picture to support communities so that they can plan ahead. Ronnie added that The Care Forum's February information sheet is about Putting People First.

Ronnie thanked Pam, particularly for clarifying the document as there had recently been misleading articles in the Press about the Concordat.

Workshops

What do people think is important in creating joint teams?

Feedback: Workshop 1

- Cohesion of the joint teams and communication between them is effective
- Training of staff – joint
- More efficient use of time/resource
- Addressing the needs of older people with mental health needs
- Listening to the views/needs of older people – building in robust feedback mechanisms in the models
- Generic assessment forms

What are the success criteria for these community teams?

Feedback: Workshop 1

- Fewer crises – admissions to hospital
- Accurate information of service users held centrally
- Reduced waiting times

- Customer satisfaction including: swift and right response to their needs, contact back into the team
- Understanding of eligibility criteria: health versus social care

Workshop 2

- Option 1 – urgent care response in one place – fits in with RUH
- Communication important – how information shared
- People in rural locations: recognise takes longer to get to services – weighting for geographical distribution to reflect this
- LINKs – formal arrangement with LINKs. Mechanisms for monitoring
- Is there a resource issue for the two models?
- Could there be a cross over AX localities → flexibility: capacity → need more info
- success
- more people worried not enough
- more money
- great opportunity to build on what people are already doing
- people referred appropriately regardless of what they need: promptly and efficiently meet needs
- people locally know how to access the service and what they are entitled to
- service provided 24/7 – 00H
- Is holistic: balancing emergency response and broad service providing information generally/signposting
- equality of access to services AX Area: rural and urban/disability/race eg language etc
- People only need to give information once
- Existing services are effectively included within provision
- joined up communications

important

- public communications strategy
- are there provisions for paramedics within villages? (emergency care practitioner system)
- nb directory of op services in production: ready soon. also leaflet about access to care services
- include pharmacists in giving info
- get funding from drugs companies
- rides or falls on how effectively LINKs and VCOs
- Managing change in service vital e.g supporting existing workers: tight timescales

important

- concerned at different area models for home care/community teams → brokerage model should help: need to build on this
- Health care and social care does need to be joined up – MH as well, simple to access.
- Relationship and VCS very important: relating to three different teams, complex for smaller VCOs. Resource implications

- What about self funders? Will they be supported too?
- Systems talking to each other **critical**. Huge communication issue
- How people work together is **critical** – training?
- How is this going to be communicated to local people? Has to be budgeted for including GPs
- Are provisions made for people and ESL?
- Differentiate between different services needed in case of urgent care as opposed to general information: balance

important

- analysis/understanding of varying needs in different areas: e.g confusion/lack of information/ are there ways of segmenting/understanding different “markets” better? Effectiveness of information giving: where do people get information? What ways do people prefer?
- 3 localities: services have to be compatible with each other and equal
- Centralised resource/base means people living in that area have better access: how tackle this?
- Rural areas: flexibility needed
- Must build on existing services
- Partnership of information and advice givers: ensure quality of information given/linked up coordinated → recognise people’s preferences in relation to where they like to get information from
- More resources for this and understanding how people prefer to get into

Date of Next Meeting: to be confirmed