



BEDFORD
BOROUGH COUNCIL



Bedfordshire Clinical Commissioning Group

Joint Commissioning Strategy for Older People 2013-2017

December 2013

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Foreword

All across Bedford Borough the number of people aged 50+ is rising and more people are living longer. This is great news. Most older people are active and healthy. Many play a key role in local voluntary organisations and community groups, or are continuing to work. Many enjoy sport and leisure activities. Many are very much in touch with modern life, using computers and other forms of technology every day.

However it is also the case that illness and disability increase as we get older. As our population continues to grow older it brings challenges to Bedford Borough Council and Bedfordshire Clinical Commissioning Group. We are responsible for commissioning good quality, efficient and personalised health and social care services for people in the Borough. We also have a duty to involve local people in decisions about how local services are delivered.

You are reading our Joint Commissioning Strategy for Older People in Bedford Borough. This builds on the previous 2010/13 strategy of BBC and NHS Bedfordshire (which BCCG has now replaced) in reviewing current services and planning for the future. The aim is to help everyone to have as independent and fulfilling a life as possible as they grow older.

We are grateful for the support of all the local people who helped drive this strategy through their involvement in the Older People's Partnership Board and public consultation events. They helped us understand what is really important to older people in Bedford Borough.

We have produced this strategy in challenging economic times, both nationally and locally. It is therefore important that services are provided in the most effective and efficient way and resources are targeted upon investing in services which have proven outcomes and deliver a measureable improvement to the health and wellbeing of older people.

With challenge comes opportunity. We will take the opportunity to do things differently with the still significant resources that remain available to us and we will make changes to transform the way services are delivered over the next four years. This will mean concentrating more on prevention and early intervention when people need services.

This strategy is the result of extensive consultation with user and carer groups and the targets within this joint commissioning strategy underline our commitment to providing services which promote health and wellbeing, social inclusion and choice for people in later life.

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Executive Summary

This is the Joint Commissioning Strategy for Older People from Bedford Borough Council and Bedfordshire Clinical Commissioning Group. It will be delivered in line with the Strategic Action Plan on pages 46 – 53. Over the five years of the strategy we will review the Strategic Action Plan annually to incorporate any changes to government policy and/or local priorities. We will continue to invite feedback from local stakeholders.

This strategy demonstrates our continuing commitment to older people having maximum independence, choice and control in how they live their lives. It needs to be read in the context of other strategic documents produced by the partners including the BCCG's Commissioning Intentions and the Joint Beds and Community Services Review.

Adult Services' vision for older people in Bedford Borough is:

'To provide excellent, safe, sound, supportive, cost effective and transformational services for older people that promote independence, well being, and choice and are shaped by accurate assessment of community needs.'

We will bring this vision closer by improving outcomes for older people in four outcome domains over the next five years.

The Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework (Department of Health) specifies outcomes in four domains. These domains have been adopted to provide the structure for Chapter 3 (Strategic Intentions for Older People) and the Action Plan.

- Enhancing quality of life for people with care and support needs.
- Delaying and reducing the need for care and support.
- Ensuring that people have a positive experience of care and support
- Safeguarding people whose circumstances make them vulnerable and protecting from them avoidable harm.

The average lifespan is increasing and so the demand for health and social care services. While the current economic climate severely limits funding, we remain committed to improving the lives of local people within available resources.

There are nearly 8,000 people over 65 in the Borough with social care needs and nearly 2,000 of them have intensive social care needs.

Bedford has one of the most ethnically diverse communities in the Eastern Region with people from an estimated 60 countries, including large Italian, Eastern European and Asian populations. We will carefully monitor the Equalities Impact of this strategy to ensure everyone in the Borough is able to benefit from it equally.

Summary of themes for this Joint Commissioning Strategy

- Person centred care involving more control to older people needing support through direct payments, greater choice, and more responsibility for self-care

- Supporting people to live in their homes for longer and providing alternatives to residential care. Services delivered will have a re-ablement focus so that people will be supported to be as independent as possible.
- Joined up services linked more explicitly to levels of need, involving re-ablement and complex care teams, a better co-ordinated primary care network and strengthened local strategic partnerships.
- Timely response to needs involving proactive approaches to prevention, population screening, and opportunistic case finding to identify problems at an early stage and prevent crisis and ongoing harm.
- Promotion of health and an active life involving reaching people who are marginalised including older people with mental health problems and those from ethnic minority communities
- Wider vision for older people involving promoting wellbeing and on-going engagement in the communities in which they live along with the right services, in the right way, at the right time.

In summary this strategy is driving a partnership approach to developing support for older people in Bedford Borough and sustaining the best possible quality of life for them and their families.

Introduction

This Joint Commissioning Strategy for Older People will be delivered in line with the Strategic Action Plan on pages 46 – 53. Over the five years of the strategy we will review the Strategic Action Plan annually to incorporate any changes to government policy and local priorities. We will also continue to invite feedback from local stakeholders.

Bedford Borough Council (BBC) and Bedfordshire Clinical Commissioning Group (BCCG) will continue to strengthen our partnership to make best use of resources. This will include more joint commissioning, contracting, monitoring and reviewing arrangements.

Government Vision for Adult Social Care

The government's vision for a modern system of social care is built on seven principles:

- **Prevention:** empowered people and strong communities will work together to maintain independence. Where the state is needed, it supports communities and helps people to retain and regain independence.
- **Personalisation:** individuals taking control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all regardless of whether or not they fund their own care.
- **Partnership:** care and support delivered in a partnership between individuals, communities, the voluntary and private sectors, the NHS and councils - including wider support services, such as housing.
- **Plurality:** the variety of people's needs is matched by diverse service provision, with a broad market of high quality service providers.
- **Protection:** there are sensible safeguards against the risk of abuse or neglect. Risk is no longer an excuse to limit people's freedom.
- **Productivity:** greater local accountability will drive improvements and innovation to deliver higher productivity and high quality care and support services. A focus on publishing information about agreed quality outcomes will support transparency and accountability.
- **People:** we can draw on a workforce who can provide care and support with skill, compassion and imagination, and who are given the freedom and support to do so. The whole workforce needs to take a leadership role.

Bedford Borough Council Vision

Our vision for adult social care is:

'To provide excellent, safe, sound, supportive, cost effective, transformational services for the residents of Bedford Borough that promote independence, health, well-being and choice and are shaped by accurate assessment of community needs.'

The Council and CCG plan and deliver services in partnership with an emphasis on early intervention and prevention to help people live independently.

Service users and carers are listened to and actively involved in planning and developing services. The Council and CCG are implementing a Health and Wellbeing strategy to promote healthy living and support all aspects of wellbeing. The Council and CCG are also fully committed to ensuring that people live at home, not in a home.

Extra Care Housing is being built to help people do that. In partnership with Bedford Hospital we continue to develop services that prevent unnecessary admissions to the hospital and facilitate a safe and timely discharge for people who are ready to return home.

The NHS Quality, Innovation, Productivity and Prevention Programme (QIPP)

QIPP is a large scale transformational programme for the NHS, involving all NHS staff, clinicians, patients and the voluntary sector and will improve the quality of care the NHS delivers whilst making up to £20billion of efficiency savings by 2014-15, which will be reinvested in frontline care.

There are a number of national and local work streams designed to achieve the quality and productivity challenge that has been set. The Council is working closely with the CCG to implement QIPP Plans locally. Services are being re-designed for people with dementia, or have had strokes, or at risk of falling or at the end of their lives.

It is especially important in times of severe financial constraints that the most is made of resources. Working together the Council and CCG can achieve that.

Delivery

Bedford Borough's Sustainable Community Strategy (2009-2021) describes seven themes being delivered to improve people's quality of life.

One of the themes, 'A Healthy Borough', sets out this goal:

“A Borough where everybody has access to high quality health and social care services when they need them and the help they need to lead healthy and independent lives”

The big challenge for this joint strategy in meeting that goal is to deliver specific older people's services when needed and ensure older people are well treated by mainstream services at other times. A joined up approach is essential with both the Council and CCG providing leadership to the system

The Council and CCG cannot improve local health outcomes to the maximum without individuals also taking responsibility for their own health. We will continue to provide many people with targeted support, advice and information to help them make better choices for their health and wellbeing.

The Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework (Department of Health) specifies outcomes in four domains.

- Enhancing quality of life for people with care and support needs.
- Delaying and reducing the need for care and support.
- Ensuring that people have a positive experience of care and support
- Safeguarding people whose circumstances make them vulnerable and protecting from avoidable harm.

These domains have been adopted to provide the structure for Chapter 3 (Strategic Intentions for Older People) and the Action Plan that follows.

Chapter 1 Older People in Bedford Borough

- 1.1 Bedford Borough covers an area of 476 sq. km and is home to 157,800 people living in approximately 64,000 households. Just under two-thirds live in the urban areas of Bedford and Kempston, with almost 36% in the surrounding rural areas. Significant new residential development is planned in the Borough with the population forecast to rise to more than 170,000 by 2021.
- 1.2 On most social and economic measures the Borough is broadly similar to national and East of England averages. However the most deprived areas of the Borough experience significantly lower life expectancy, with a difference of up to 14 years in life expectancy between the most deprived and least deprived areas.
- 1.3 Bedford is experiencing major growth in the numbers of older people. The ageing of the Borough's population will accelerate in future years with the 65+ and 80+ age groups both rising by nearly 30% between 2011 and 2021. The 85+ population will rise by almost 47% in that period which will represent a significant ageing of the Borough's population.
- 1.4 Bedford Borough has an ethnically diverse population and is home to people from an estimated 60 countries, including large Italian and Asian populations. Black and ethnic minority groups formed 28.5% of the Borough's population in 2011 compared to 20.2% nationally (or 13.9% if London Boroughs are excluded).
- 1.5 The BME population is concentrated in the urban areas, 58% of Queens Park and 44% of Cauldwell residents are from BME groups.
- 1.6 Health in Bedford Borough is generally similar to the England average. The average life expectancy is 80.2 years however life expectancy in the most deprived parts of Bedford town is estimated to be 11 years less than in the most affluent wards – for women the difference is almost 5 years. The urban areas of the Borough also have a greater proportion of people suffering a limiting long term illness or disability.
- 1.7 Using 2007 deprivation measures, Bedford Borough is in the mid-range of English local authorities, but parts of Bedford and Kempston experience considerable deprivation, which is where a higher proportion of people from minority ethnic groups live. Areas in Castle, Harpur and Cauldwell wards are amongst the 10% most deprived areas in England. Castle and Harpur wards both have large proportions of older people who live on their own and are at risk of loneliness.
- 1.8 Pensioners living in Bedford and Kempston are twice as likely to be income deprived as rural pensioners, with levels reaching 57% in the most deprived parts of Castle ward in central Bedford.
- 1.9 People living in the rural areas of the Borough do not generally suffer from significant general or income deprivation. However, they do suffer from reduced accessibility to essential services as transport, banks, post offices, schools and primary care.
- 1.10 Given the older age profile of rural areas and the high rates of care provision by older people in rural areas, access to services is an important issue for older people.

- 1.11 Approximately 15% of older people are in regular contact with care services. Older people make up 16% of the population, but occupy almost two thirds of general and acute hospital beds and account for 50% of recent growth in emergency admissions.

Illness

- 1.12 The main illnesses affecting older people in Bedford Borough are heart disease and cancers, with pneumonia also a common cause of death.
- 1.13 The main reasons for people being admitted to residential and nursing care homes are:
- Dementia
 - Stroke
 - Frailty
 - Arthritis
 - Family/social reasons
- 1.14 Admission to care homes is usually triggered when a person's care needs change (perhaps having regular night time needs) and there are insufficient resources at home to cope. In order to reduce the number of avoidable admissions to care we intend to intervene early and meet most people's needs at home rather than in a home. This is a cost effective way of working because early intervention delays or prevents the need for more intensive (and costly) interventions at later date.

Dementia

- 1.15 Dementia is a condition with a collection of symptoms including a decline in memory, reasoning and communication skills, and a gradual loss of skills needed to carry out daily activities. These symptoms are caused by structural and chemical changes in the brain as a result of physical diseases such as Alzheimer's disease. (*Source: Dementia UK, Alzheimer's Society, 2007*)
- 1.16 The prevalence of dementia increases markedly with age, with an approximate doubling in prevalence every 5 years over the age of 65. As the number of older people is forecast to increase we expect a substantial increase in cases of dementia.
- 1.17 The number of people aged 65+ in Bedford Borough with dementia that results in severe cognitive impairment and functional disability is projected to increase by 80% between 2008 and 2028.
- 1.18 Dementia is such an important factor it has its own Joint Commissioning Strategy.

Social Care Needs

- 1.19 Estimates and long term projections of social care for older people were commissioned by the Council in 2008. The number of people aged 65+ with social care needs was projected to rise by 65% over 2008-2028, well above the national increase (52%). This figure may need to be revised following release of 2011 Census data.

Chapter 2 Current Context

Legal Basis

Health and Social Care Act 2012

2.1 The NHS needs to change to meet the challenges it faces for three main reasons.

2.2 **Rising demand and treatment costs.** The pressures on the NHS are increasing, in keeping with health systems across the world. Demand is growing rapidly as the population ages and long-term conditions become more common; more sophisticated and expensive treatment options are becoming available. The cost of medicines is growing by over £600m per year.

2.3 **Need for improvement.** At its best, the NHS is world-leading, but there are important areas where the NHS falls behind those of other major European countries. If we had cancer survival rates at the average in Europe, we would save 5,000 lives a year.

2.4 **State of the public finances.** Whilst the Government has protected the NHS budget, this is still among the tightest funding settlements the NHS has ever faced. Simply doing the same things in the same way will no longer be affordable in the future.

2.5 The Health and Social Care Act 2012 introduces Clinical Commissioning with a greater role for doctors in managing the system and a greater voice for service users in how priorities should be set and services delivered.,

2.6 Local Authority's duties are set out in:

2.7 **NHS & Community Care Act 1990 - Section 47(1):**

The Local Authority has a duty to carry out an assessment of need for community care services where a person appears to be someone for whom community care services could be provided, AND a person's circumstances may need the provision of some community care services.

2.8 **Section 47(2)**

If the Section 47(1) assessment identifies a person as being disabled, that person has additional rights as set out in Section 47(2) which requires local authorities to decide as to the services required under the...

2.9 **Disabled Persons (Services and Consultation and Representation) Act 1986 - Section 4:**

Under this Act the local authority must decide whether the needs of a disabled person require any services.

2.10 **Chronically Sick & Disabled Persons Act 1970 Section 2(1):**

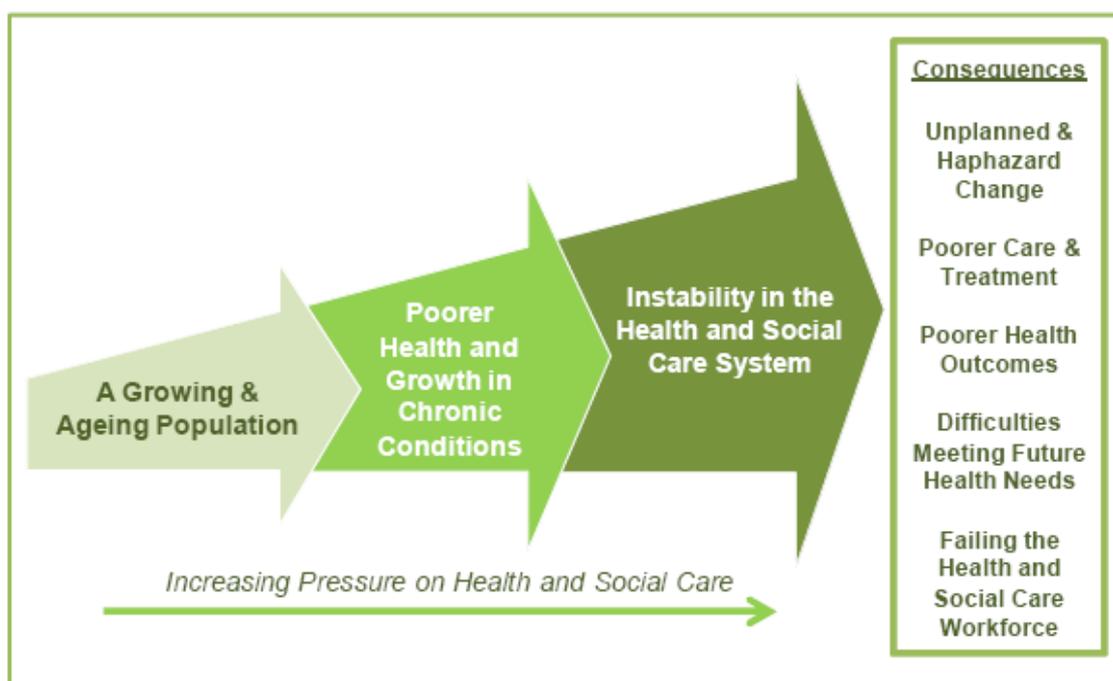
Under this act the local authority must assess the needs of people who fall within the **National Assistance Act 1948**.

2.11 **National Assistance Act 1948 - Section 29(1)**

This Act defines a 'disabled person'.

Local Drivers

- 2.12 There is general agreement that the whole health and social care system needs to change or it will not be able to meet future needs within available resources. The diagram below summarises the consequences if we do nothing. Pressure to use resources effectively is intense now and will continue to grow.
- 2.13 Bedford Borough is not in a unique position. Most of the issues are common in other areas of the UK. 'Healthcare for London' set out similar issues, as did the Scottish Government's 'Shifting the Balance of Care' and NHS Wales' 'Together for Health'.



- 2.14 The Bedford Borough system has experienced major change in recent years. The unitary council has arrived. A new secondary mental health provider is in place, and a new community health provider. Tiers of infrastructure have been removed from the NHS. The CCG is taking over from the PCT.
- 2.15 But other features persist or change only slowly. There is still systemic over reliance on hospital beds. Services are not taking full advantage of new technologies. We are not sufficiently changing public and professional behaviour to act quickly and preventatively. We still have a growing and ageing population with an increasing prevalence of long term conditions. We still experience workforce supply difficulties and need greater productivity and value for money.

Needs now and in the future

- 2.16 Older people are the main consumers of social care and health services. People in other client groups are important but to make a big impact quickly requires an initial focus on older people.
- 2.17 The forecast for Bedford Borough is an 11% increase in the number of people aged over 65 in the next 5 years and a 21% increase in those aged over 90.

- 2.18 Looking to 2035, the population in the 85+ bracket is forecast to increase by 160%. We expect the number of people with dementia to have risen from just under 2,000 now to around 3,500 by then.
- 2.19 A lot more older people will need services in the future and we need to plan how the system will cope.
- 2.20 The plan needs to be flexible to cope with unforeseen events between now and 2035 such as treatments for cancer and dementia or the failure of antibiotics.
- 2.21 Acknowledging some uncertainty, it is reasonable to plan for the next 10 years based on what we know today. The closer we are to today the more certain we can be of the forecast.
- 2.22 We are confident there will be around 2000 more people over 65 between now and 2016. As a result if we do nothing differently, we would expect about 100 more people in council funded residential or nursing care. That will not be affordable and probably not be the best outcome for those 100 people either.
- 2.23 The forecast of is around 10% rise in the number of people with Dementia in the next 5 years. There are around 700 people registered with dementia today. 10% more in five years will make that figure 770. That is 14 more people per year which should be manageable if we re-organise. Our Joint Dementia Strategy includes work to identify people earlier in their dementia journey. We expect to identify more people earlier but people with dementia in that group will probably not be at the stage of being eligible for social care and support.
- 2.24 'Double digit' percentage growth in other conditions between 2012 - 2016 gives us numbers that we should be able to manage if we do things differently. Many of the people counted are counted in more than one set of disease statistics.

Summary forecast disease prevalence increase 2012- 2016 (POPPI)

Bedford Borough	% increase	Estimated no.
Dementia	10	190
Diabetes	11	370
Stroke	9	20
Bronchitis and emphysema	11	50
Long standing conditions caused by heart attack	10	140
Falls Hospital admissions	9	50
Limiting long term illness	11	1300
Limiting long term illness living alone	9	310

Admissions to residential or nursing care

- 2.25 Projecting Older People Population Information (POPPI) is the 'industry standard' demography prediction tool for older people. The POPPI forecast below tells us that if we don't change we will have an estimated 300 more people in care homes in 2020 (150 council funded, 150 'other' funded). That would not be consistent with our vision to care for people at home, not in a home.

	2012	2015	2020	2025	2030
Total population aged 65 and over living in a care home with or without nursing	1,017	1,139	1,323	1,570	1,845

- 2.26 These forecasts are statistical estimates and we can compare them with the actual number that we know about today. The current actual number placed by Adult Services in care homes is less than half of the total current actual number of care home places available in the Borough (411/1144). The majority of places (733/1144) are taken by people who are not funded by the Borough. A number of them will be private payers and a number will have been placed by neighbouring authorities, most likely Central Bedfordshire and Northamptonshire.
- 2.27 It is usual for data from different sources not to match exactly but taken as a whole all the data available suggests population and needs increasing at a rate that will not be sustainable within resources and must be reduced if not ideally reversed.
- 2.28 We have already started to reshape our offer. Our admission rate to care homes is reducing as a consequence of Extra Care now being available (184 places), the introduction of reablement for all (with few exceptions), and changes in practice by social work teams who now make the safeguarding and care of people at home their top priority and recommend care homes only when 'at home' is not viable. In response to the culture change we have been promoting there is growing local demand for domiciliary support (with aids and adaptations as necessary) to support independent living in people's own homes for as long as possible.

Current Services

Bedford Borough Council

Assessment and Care Management Team

- 2.29 Based at Borough Hall, a mix of social workers and support workers provide assessments of need and organise care packages. Packages may involve home care, personal care, respite, day care, nursing or residential care, or increasingly direct payments so that people can meet their care outcomes by purchasing their own care.
- 2.30 The Council has a stated aim of reducing the use of residential care and supporting people to live in their own homes or to live in supported accommodation with their own tenancies. The Borough Council is supporting the delivery of extracare schemes and sees extracare as a major way of reducing the use of institutional care.

Hospital Social Work Team

- 2.31 Based in the hospital, this team facilitates timely discharge by ensuring support is in place when the person returns home. The team has been ambitiously re-configured and is now working during weekends as well as during the week. This helps people to come home as soon as they are able, and regain their level of functioning sooner.

- 2.32 The hospital social work team has access to the community equipment service at weekends too, which further helps facilitate people going home as quickly as possible with the support they need being in place.

Re-ablement Service

- 2.33 This home based service provides up to 6 weeks assessment and re-ablement. The aim is to improve the person's skills so they can return to independent living following trauma such as a fall or stroke. The team also assesses and identifies appropriate home care support if needed beyond their 6 weeks involvement. The service is currently working in partnership with Everycare, a private home care service that specialises in re-abling people. Everycare works with people who have been discharged from hospital and the Council's in house service works with people who are living at home and have had a change in their level of functioning.

Day Centres

- 2.34 The council currently runs 2 day centres in Goldington Road and Conduit Road. The Goldington Road Day Centre is the main day centre and is currently at 75% capacity. It has recently been refurbished and the bathing facilities improved. It is used by people who are physically frail and/or have dementia.
- 2.35 Conduit Road Day Centre is a smaller service and is predominantly used by people from Black and Minority Ethnic Groups. It is currently at 50% capacity. The day services are limited to 'office hours'. Transport can be provided if needed and many people do use council transport to come in.
- 2.36 The Council also commissions a small day centre from BUPA, on the Rivermead Care Home site in Kempston. This service meets the needs of older people with dementia and is at 50% capacity.
- 2.37 As part of the Council's modernisation proposals the Council will be looking to re-configure older peoples day care and to promote alternatives to traditional day care. Conduit Road and Rivermead Day Centres are both running well under capacity so the Council will review these to evaluate how well they deliver value for money.

Occupational Therapy Team

- 2.38 This team assess people's needs (all ages) and make recommendations for equipment, minor works or major adaptations to homes to increase people's independence and enable them to live in their own home for as long as possible.
- 2.39 Assessment and reviews for telecare are undertaken in the same way as the other assessment and review activities and form part of the standard care pathway.

Care Standards Review Team

- 2.40 This team carry out annual reviews for all service users including older people. They make sure people are getting their support delivered to a good standard and the person's assessment of need remains current.

- 2.41 A Welfare Rights Service is provided to children and adults from all user groups to people known to social services as part of their financial assessment under the charging policy (Fair Access to Care Services, FACS). The service makes sure that people are claiming the benefits that they are entitled to and is able to increase household incomes.
- 2.42 The Council's Blue Badge parking permit and concessionary fares scheme is available for older people and people with eligible disabilities to help them travel independently.

South Essex Partnership Trust (SEPT)

- 2.43 South Essex Partnership Trust (SEPT) is commissioned by NHS Bedfordshire and Bedford Borough Council to provide specialist health and social care services to older people with mental health needs who live in the Borough. SEPT is also commissioned by the PCT to deliver community health services.
- 2.44 Community Mental Health Teams (CMHTs) for Older People offer comprehensive assessment, treatment and care to people either in their homes or in the community.
- 2.45 The Acute Assessment Units consist of five units across Bedford and Luton for older people experiencing ongoing mental health problems of a functional and/or organic nature. These services offer multidisciplinary assessment, treatment and care. Service users and carers are fully involved in the delivery of care. One of the units provides long-term nursing care to older people with an organic mental health disorder.
- 2.46 The community health services that predominantly support older people include rapid treatment for people in medical crisis, to avoid hospital admission, intermediate care and reablement for people leaving hospital, podiatry, district nursing, wheelchair service, continence service, tissue viability nurses, community matrons, specialist nurses such as the Parkinson's nurse. Nutrition and dietetics staff and speech and language therapists can advise healthy eating and support people with swallowing problems.

General NHS Services

- 2.47 These are not Bedford Borough or Older People specific but they are key services for older people locally.

The Archer Unit

- 2.48 Provides short term in-patient rehabilitation and support, for patients who meet the service criteria, with the aim of optimising individual level of function. Patients receive a multi-disciplinary assessment and individualised treatment programme, with regular reviews and pro active discharge planning.

Community Nursing Service

- 2.49 The community nursing service works to provide evidence based nursing care. The key aim of the service is to avoid unnecessary hospital admissions by providing

timely care for patients in their own homes and facilitating timely discharge from hospital.

Community Matrons

2.50 Currently, many patients who have complex long term conditions (LTC) and high intensity needs are admitted into an acute hospital on an unplanned basis. The management of these patients is generally reactive rather than proactive. The Community Matron Service offers a community based proactive response to complex Long Term Conditions and high intensity needs. Each community matron will work within a population size of about 50,000 people, with a caseload of around 50 active Very High Intensity Users aged over 18 years of age.

Rehabilitation and Enablement Service

2.51 A multi-disciplinary service consisting of Physiotherapists, Occupational Therapists, Assistant Practitioners, Rehabilitation Support Workers and Social Workers. The service uses a patient centred approach and works in partnership with patients, and where appropriate their relatives and/or carers, and other community teams or services involved. The service works to prevent unnecessary admission to acute hospital or nursing/residential care, and coordinate with acute and secondary care colleagues to facilitate timely discharge from hospital.

Rapid Intervention Service

2.52 The Rapid Intervention Team work to prevent avoidable hospital admissions, and support appropriate early discharge by providing rapid assessment of patients and access to short term community based nursing, therapy, personal care, medical support and some investigations.

Continence Service

2.53 The key aim of this service is to provide continence services to patients living in their own home or a care home and provide a high quality, cost effective and productive service that enables innovative practice and meets individual patient needs.

Chapter 3 Strategic Priorities for Older People

Strategic Priority 1: Enhancing quality of life for older people with care and support needs.

Involving People

- 3.1 There are many associations working to champion the voice and rights of older people in Bedford Borough, and the Council is committed to working with these groups.
- 3.2 The chance to be involved and consulted about services for older people should not be limited to people aged 50+ who are officially 'service users'. Planning future services and getting existing services right is relevant to everyone and not just those people who are currently in need of health and welfare support. The needs and expectations of the 50+ generation, whether service users or not, will be very different from existing 'older people' and they need to be involved effectively to properly direct future provision.
- 3.3 Increasing demand and economic pressures highlight the value of looking first at what channels for involvement and engagement already exist and work well within the community, while also thinking creatively about new ideas. There is a great resource to be tapped into of local services, good practice and expertise, in some cases developed over many years and already involving large numbers of local older people. Good communication and proper partnership working can capitalise on this for everyone's benefit.
- 3.4 From April 2013 Healthwatch Bedford Borough will be in place with a statutory role to bring the voice of the people to the highest levels of local planning and decision making. The Chair of Healthwatch Bedford Borough will be a member of the Health and Wellbeing Board. Bedford LINK is evolving into Healthwatch and while 1/4/13 is an important date it does not represent the end of the process. The Council and CCG will both work hard to support Healthwatch Bedford Borough in its new role.

Transport

- 3.5 Transport provides an essential link to friends, family, essential services and the wider community and is fundamental to maintaining independence. A lack of mobility can prevent older people from participating in social activities and lead to low morale, depression, social isolation and loneliness. Being able to go out shopping is about more than just buying food or clothes - it is an experience, a reason to go out and interact with others.
- 3.6 Bedford Borough has produced a Local Transport Plan. The aim of the plan, which addresses community and public transport developments, is to improve the quality of life and economic prosperity within the Borough by connecting communities and improving access to services and amenities.
- 3.7 Local Authorities have a duty under Section II of the Chronically Sick and Disabled Persons Act 1970 to provide transport to support day services. At present, the Borough operates a number of routes to day centres for older people via its own vehicles.

- 3.8 In line with personalisation the provision of transport in the future will need to be on a more individual basis and the challenge will be to examine how best that can be achieved.
- 3.9 There is a local transport network operating in Bedfordshire which offers a variety of services and journeys. Currently 80% of bus services are operated on a commercial basis. Bus routes in certain areas are being developed by replacing existing vehicles with new low-floor buses and improving the frequency and timing of the routes.
- 3.10 The Council funds a range of transport services provided by a number of voluntary organisations. These may be provided by volunteers or paid staff, and are generally responsive to meeting the needs of their local community. There are Dial-a-Ride Schemes, which provide a door to door service for older people who are unable to use ordinary transport. There are also a number of community bus schemes which offer the public a variety of journeys to locations that other public transport does not provide.
- 3.11 A single journey can use a mix of transport options including:
- Public transport – such as buses and trains.
 - Demand Responsive Transport – Transport with flexible routing and scheduling
 - Community Transport – Flexible transport often provided by volunteers.
 - Active Transport – walking and cycling.
 - Mobility Scooters

Local Transport Plan 3 (LTP3) (2011-2021)

- 3.12 Transport plays a vital role in helping people have an active social life and reach the services and facilities they require, thereby promoting social inclusion and community life. The role of transport becomes even more important in the context of an ageing population.
- 3.13 The Local Transport Plan Vision is
- To create a transport system in which walking, cycling and public transport are the natural choices of travel for the majority of journeys because they are affordable, healthy, convenient and safe alternatives to the private car.*
- 3.14 The Local Transport Plan comprises 8 distinct but related transport strategies, which can work in conjunction to help support the aspirations of this older people's strategy.
- 3.15 These are:
- Network Management Strategy
 - Transport Asset Management Plan
 - Active Travel Strategy
 - Public Transport Strategy
 - Parking Strategy
 - Road Safety Strategy
 - Sustainable Modes of Travel to School Strategy

- Freight Strategy

3.16 Certain Local Transport Plan strategies are of primary importance to be delivered jointly, namely:

Network Management Strategy

- 3.17 The maintenance of good quality pavements, footpaths and cycle paths is imperative. Trips and falls result in an appreciable number of admissions to hospital and falls can have significant longer-term health impacts.
- 3.18 Adult services will work with Highways in the context of the local transport plan to understand the scale of trips and falls in the highways environment and explore potential opportunities for investment where net cost benefit can be demonstrated.

Active Travel Strategy

3.19 The active travel strategy seeks to encourage walking and cycling as healthy alternative means of transport to the private car. The active travel strategy will work closely with network management in order to create an environment which is pleasant and which encourages more walking and cycling by providing more road crossing opportunities at important locations and reducing speed limits.

Passenger Transport Strategy

- 3.20 Public transport issues are reflected in each of the Bedford transport challenges and have been particularly identified as means of developing a strong economy, increasing accessibility by non car modes and promoting a low carbon network.
- 3.21 The priorities for passenger and public transport, which have been set by stakeholders and reflect local priorities, include:
- Improving accessibility to services, facilities, employment, education etc. for all members of the community, including disabled, vulnerable and elderly travellers.
 - Increasing transport choices, in line with the “Putting People First” (social care personalisation) agenda.
 - A growing and ageing population
 - Limited funding for the support of public transport services and for the provision of bespoke client transport service.
 - High cost of bespoke client transport.
 - Current client service delivery arrangements with regard to establishment opening times.
 - Reducing congestion and promoting sustainable transport within the carbon agenda.

Public transport aims

3.22 In order to contribute to the wider transport strategy set out in the Local Transport Plan, the Council is seeking to promote and develop public transport for two primary reasons:-

- To reduce social exclusion by providing access to a wide range of opportunities for those without a car available.
- To provide the public with a wider range of travel choices as an alternative to the private car, thereby contributing to reducing congestion, which will reduce air pollution and carbon emissions, improve road safety and support economic sustainability

Client transport aims

3.23 Currently, the level of spending on bespoke client transport (Adults' and Children's services) far exceeds the funding available for public transport services support and development. In order to increase value for money and benefit all members of the community there is a need to:-

- Encourage, support and enable clients to use public transport rather than bespoke client transport.
- To maximise the efficiency of client transport and encourage, support and enable clients (where appropriate) to use public transport rather than bespoke client transport.
- Invest in the extension and improvement of the accessible public transport network across the Borough.

Parking Strategy

3.24 Older people often rely on a private car to maintain mobility and independence. Bedford Borough operates a Blue Badge Parking scheme and through the parking strategy seeks to ensure that people for whom the car is a life line have easy access to the town centre and other key destinations.

Road Safety Strategy

3.25 The road safety strategy provides an opportunity to investigate and understand the nature of road casualties and risk associated with road use in Bedford Borough for all users. Specific casualty analysis alongside health service records and other intelligence into the vulnerability of older people in the highway environment will be undertaken. This will be used to inform wider strategic partnerships aimed at delivering a safe accessible highway network.

Libraries

3.26 Libraries play an important role in helping older people and carers to improve the quality of their lives and gain access to services. This service is provided through a network of five libraries, a Virtual Library, a mobile library which visits communities across the Borough, and a Library Link vehicle which reaches people unable to visit a library.

3.27 The Library Service provides access to a wide range of books and other materials, including large print, audio books on CD, DVDs, magazines and music. An increasing range of resources are available online through the Virtual Library, including e-books and e-audio.

- 3.28 The service also supports over 80 Reading Groups which provide a social opportunity to read and discuss a wide range of books. They are very popular with older people and include a reading group for people with a visual impairment.
- 3.29 Libraries provide access to good quality information and signpost carers and older people to relevant advice and support groups. Partner organisations also provide services in libraries, including advice sessions such as careers & benefits advice and training opportunities including ESOL, basic skills and IT skills.
- 3.30 The Virtual Library is the Borough's online library service and is available 22 hours per day, 7 days a week. As well as being able to search the catalogue and manage your account online it also includes various sections designed to be of interest to older people.
- 3.31 Learning opportunities are available in libraries which enable older people to obtain new skills and develop self confidence. These include one to one IT taster sessions in how to use a computer or trace your family history. Libraries also provide space for partner organisations to offer services to older people, such as the Silver Surfer's Computer Club at Kempston Library.
- 3.32 Also available are community history projects which have included the history of the high street and cinemas in Bedford.
- 3.33 Libraries provide a venue for social interaction – they are community spaces where everyone is welcome with friendly, helpful staff who have the knowledge and skills to help customers and provide good quality services. As well as being a local meeting place libraries offer a range of events and activities – some specifically for older people such as 'Down Memory Lane' and 'Knit and Natter'. Other activities are delivered in libraries by partner organisations such as Sports Development and the Retirement Education Centre.
- 3.34 The Library Link Service provides a library service to people who are unable to reach their local library due to ill health, mobility limitations, visual impairment or other reasons. It is delivered via a specially adapted Library Link vehicle that visits homebound users and sheltered housing schemes, and supported in part by volunteers.

Parks and Green Spaces

- 3.35 Good quality publicly accessible green space is critical to the health and well being of the community, delivering physical and mental health benefits and improving physical and social inclusion for all ages and abilities. The Council, as the principal green space provider in the Borough, has recently produced a strategy to guide green space planning, management and investment across the Borough for the period 2012-21.
- 3.36 The Borough benefits from an impressive range of high quality parks and green spaces, which provide opportunities for people to exercise and socialise in a safe, welcoming and attractive outdoor physical environment. They also provide an important venue for cultural, social and community events and activities, including festivals, fairs and concerts.

- 3.37 The Council actively promotes opportunities for older people to help, as volunteers, in the management of its parks and green spaces, including tree planting and shrub management. On some sites, such as Harrold-Odell Country Park and Mowsbury Hill Fort, individual volunteers have organised themselves into self managed 'friends groups' and carry out a wide programme of green space management and promotion duties on behalf of the Council.

Rights of Way

- 3.38 The Council is responsible for over 900 kms of public footpath, bridleway and byway in the Borough. These public rights of way are a valuable community asset, delivering a range of public benefits, including free access for people to enjoy the local countryside either on foot, bicycle or horseback.
- 3.39 The Council has recently produced a rights of way improvement plan, which sets out a programme of network improvement actions over the period 2012-17 in accordance with both present and future user needs. The plan's overall aim is to maximise community use and enjoyment of the Borough's rights of way, including making paths more accessible; supporting community led initiatives, such as volunteer led health walks; and engaging volunteers in surveying and maintaining paths. Older people are a particular target group of this aim and its associated initiatives.

Volunteering

- 3.40 The voluntary and not for profit sector is a major part of local service provision and older people form a large part of the voluntary workforce. The contribution of these volunteers and their organisations to the health and welfare system is immeasurable.
- 3.41 There are a number of agencies co-ordinating opportunities to volunteer in the Borough. The Council for Voluntary Service is supported by the 'Do It' website (a website where you can search for volunteering opportunities in your community). The Bedford Volunteer Centre have worked with approximately 200 organisations and have over 400 volunteering opportunities including placements in leisure and community centres, Library Link Service, environmental and wild life trusts, countryside conservation as well as in Health and Social Care settings.
- 3.42 Adult Education are also committed to working with the voluntary sector especially in the context of the Skills for Life programmes including to Level 2 Certificate in Community Volunteering.

Employment

- 3.43 Even before the current economic downturn the over 50s were under-represented in the general workforce.
- 3.44 Employment beyond State Pension Age was also growing as older people exercised their option to stay in work either for wages or personal satisfaction. Many chose to work part-time, and many are self-employed.

- 3.45 The current economic downturn and the prospect of a much weaker labour market over the next few years will make it increasingly difficult for older workers to find employment or to retain their jobs.
- 3.46 Research by the Department for Work and Pensions suggests that people who carry on working beyond state pension age tend to be healthier, wealthier, and happier than those of similar age who are not working. (*Source: Working After State Pension Age, DWP, 2003*)
- 3.47 Working after state pension age is not a choice every person will make. However, it will be increasingly important that the option is available for as many people as possible. For those that chose not to work, information about volunteering activities, education opportunities, new hobbies or interests and options for physical activity needs to be readily available so that people can find things to do that promote good physical and mental health in older age.
- 3.48 Many Adult Education programmes include volunteering in their courses. Employment schemes routinely seek out volunteering placements for people as part of beginning or returning to work strategies. The economic downturn may mean more people are available as volunteers.

Welfare Rights and Benefits

- 3.49 Non take-up of benefits is a major cause of income deprivation, with many people failing to apply for benefits they are entitled to.
- 3.50 Vulnerable groups at risk of not receiving their full benefits entitlement include, older people, BME groups (particularly where the first language is not English), people with mental health problems; unpaid carers; and travellers.
- 3.51 Reasons for non take-up include the complexity of the benefits system and lack of awareness or understanding of the rules or what is available, difficulty in dealing with bureaucracy and completing applications, and reluctance to claim.
- 3.52 In recent years the Council has provided a Welfare Rights Service for service users in partnership with the Department of Work and Pensions (DWP) to provide front line advice and assistance to older people.
- 3.53 Due to key workers leaving the Council in 2012 the service could no longer be provided by the Council. Instead it has been re-commissioned with a suitable local provider (Citizens Advice Bureau).

Our Commitments

Strategic Priority 1: Enhancing quality of life for older people with care and support needs.

We Will:

1. Ensure Healthwatch Bedford Borough is successfully launched and integrated into the local system during 2013.
2. Adult services will work with Highways in the context of the local transport plan to

- better understand trips and falls in the streets and identify what can be done to reduce them within resources.
3. Encourage, support and enable clients to use public transport rather than day services transport.
 4. Increase volunteer engagement in the management and promotion of Council owned parks and amenity green spaces.
 5. Increase older peoples' access to the rights of way network by removing barriers and improving structures.
 6. Improve older people's health and well being through development and promotion of opportunities for outdoor exercise.
 7. Increase volunteer engagement to assist the Council with rights of way survey, maintenance and promotion works.
 8. Review the support available to older employees in the Council.
 9. Monitor the effectiveness of the newly commissioned welfare rights services from Citizens Advice Bureau
 10. Ensure older people and carers help decide what services should be provided, how they should be delivered and how well they are being delivered.
 11. Increase the number of older people who are volunteers, especially from 'hard to reach' groups.

Strategic Priority 2: Delaying and reducing the need for care and support.

Older People's Accommodation Strategy 2011 – 2016

- 3.54 The accommodation that people have to live in is a major determinant of how well they can cope with the demands of everyday life.
- 3.55 The key features of Bedford Borough's current and projected demographic structure with implications for older people's accommodation are:
- 3.56 The number of people aged 65+ is forecast to rise by 59% between 2010 and 2030. Older age groups are projected to rise by much higher levels with those aged 80-84 increasing by 74% and the aged 85+ population increasing by 123%.
- 3.57 The number of people aged 65+ as a proportion of the total population will rise from 15.7% to 22%. This will create increased demand for personal support and care. The need for nursing and residential services to provide support and care will be reduced by planned growth in Extra Care accommodation and other community support services.
- 3.58 There are very high rates of home ownership among older people in Bedford Borough and the proportion of older people living as couples in owned

accommodation will increase, primarily due to improved male life expectancy. This will result in couples remaining in their own homes later in life.

- 3.59 While renters are a minority among older people, they are concentrated in the more deprived wards and have poorer health at an earlier age and a higher proportion living alone compared to people in owned accommodation. The overall demand for rental sheltered housing in the Borough is forecast to decline but will continue to be a strong demand generated by these groups.
- 3.60 The Borough's rural area has a higher proportion of older people but the total numbers are small relative to the large concentration of older people in the urban wards.
- 3.61 The wards on the edge of the urban area are where most of the planned residential development over the next 20 years will be located.
- 3.62 The aspirations of older people are changing. Most significantly, more people are expressing a desire to remain within their own home and receive care in that setting.
- 3.63 Our plans include the increased availability of telecare, telehealth and reablement services, the requirement to reduce reliance on domiciliary care in the light of shrinking care budgets, and increasing pressure on budgets for aids and adaptations provided to homeowners by the Council with more people wishing to remain at home.
- 3.64 In 2011 we modelled that approximately 500 additional units of specialist accommodation for older people would need to be developed in the next 3 to 5 years. In order to achieve this, a number of actions are being undertaken including:
- the development of 150 Extra Care housing units for sale in accessible locations within the urban area of Bedford/Kempston by 2014
 - Identification of suitable sites for the development of 200 sheltered housing/assisted living units for sale
 - New housing developments to have 10% of homes built to the Lifetime Homes standard
 - Retendering for the 6 Council owned registered care homes
 - Forward planning to meet increased demand for aids and adaptations, including telecare, telehealth and reablement
 - Review sheltered housing stock for rent with landlords to identify potential schemes for decommissioning, or upgrading
- 3.65 The full Older People's Accommodation Strategy (2011 – 2016) contains more detail and 'five year' objectives in addition to the three year objectives listed above.

The Supporting People Programme

- 3.66 The Supporting People programme provides housing related support services to help vulnerable people live independently. It is a key contributor to promoting and sustaining the independence of vulnerable people through the range of services it funds. Supporting People and Operational Housing are working together with Adults Social Care to better integrate the commissioning of housing and social care.

- 3.67 The services commissioned by the Supporting People team include supported accommodation, community alarms, and floating support services. Supporting People also plays an important role in preventing avoidable admission to residential care and to reducing the impact of health related problems connected to poor housing conditions or tenancy breakdown.
- 3.68 The Supporting People Strategy 2012-2017 Consultation outlines the proposed reshaping of services to Older People to make them more accessible and relevant to them. It proposes that services which were previously only available to sheltered housing tenants will no longer be restricted in the same way. This means that older people will be able to receive low level housing support in their own homes rather than having to move into a new property in order to receive it. Alongside the continued development of Extra Care housing, this will ensure a range of options are available to older people in Bedford Borough.

Living Alone

- 3.69 Many older people live alone and more older women are living alone than older men (except for a few areas in Castle and Harper wards). Living alone can often lead to loneliness and isolation, depression and other adverse effects on health and well being.
- 3.70 The SCIE research briefing 'Preventing loneliness and isolation, interventions and outcomes' says that: 'Wayfinder' or 'community navigator' interventions have been effective in identifying those individuals who are truly socially isolated or lonely and in ensuring signposting to appropriate services; there is good evidence that befriending services are effective in reducing depression and cost-effective when compared with usual care.

Village Agents ('Just Ask!')

- 3.71 In Bedford Borough the 'community navigator' role is met by Bedfordshire Rural Communities Charity who are commissioned by the Council to employ part-time Village Agents (10 hours/week) in Bedford Borough villages who act as a bridge between vulnerable and isolated people and local support networks and services. This increases these people's independence and contributes to their health and well-being, in a way that helps to reduce barriers to service promotion and delivery in rural areas. Agents also offer the opportunity for cost savings through better targeting of service promotion and delivery, more joined-up working (i.e. the 'total person' approach), and through early intervention and prevention.
- 3.72 The help that Agents provide is wide-ranging. Sometimes it is a relatively simple matter of accessing one-off items such as disability resources, home security devices or a free bus pass. It might involve accessing ongoing support such as financial benefits or community transport services. For other people it is about including them within existing support networks such as lunch clubs, or identifying a volunteer to help with the gardening.

Village Care Schemes

- 3.73 The Village Care Schemes are also commissioned by the Council from Bedfordshire Rural Communities Charity. They are 'good neighbour' groups set up and run by local residents to provide a 'safety net' for their village or ward area, responding to calls from any fellow resident in need of a bit of extra help. They currently operate in Brickhill, Clapham, Felmersham & Radwell, Great Barford, Renhold, Sharnbrook and Wilstead
- 3.74 All volunteers are fully insured and Criminal Records Bureau checked. Most help is free, unless expenses such as petrol or parking have been incurred, but donations are always welcome. Volunteers do not take on tasks best suited to trained professionals or the emergency services but can help out with the occasional things that can make all the difference, such as lifts to the shops or doctors; collecting shopping; small household jobs such as changing a light-bulb or setting up a DVD recorder; walking the dog; even popping round for a chat over a cup of tea – or anything else that one neighbour might do for another.
- 3.75 The SCIE research briefing on loneliness also goes on to say that 'Creative groups tailored for differing interests and needs lead to reductions in loneliness and re-engagement with the wider community, and demonstrate that 'the deteriorating health effects of loneliness may be reversed by an intervention which socially activates lonely, elderly individuals'. This is taken on board by the Council's day opportunity services for older people and the various creative activities provided by local clubs such as the Guild House as well as the Council's leisure and culture services that enable friendship groups based on a wide range of interests to remain available in later life.

Physical Activity

- 3.76 A Sports Development Officer (18½ hours per week) is employed to deliver activities for older people in rural areas of the Borough. The Sports Development Team also deliver an annual programme of physical activity courses (in the region of 80 courses / year) for over 50s, plus an externally funded ongoing initiative of gentle exercise for over 70s. Concession rates apply via the Bedford Leisure Card for the over 60's, people with a disability and those on a range of benefits.
- 3.77 The Borough offers a range of physical activities including the GP Exercise Referral Scheme (developed in partnership with NHS Bedfordshire) and Re-Active8 Gold which encourages older people to participate in physical activity. A new "pay on the door pre-Active8 initiative" is also running with the aim of introducing new participants to activity prior to enrolment on pre paid courses
- 3.78 Leisure centre (all buildings disability adapted) activities relevant to older people include;
- Gentle swim at Kempston Pool; Adult Only at Robinson Pool and Relax and Swim at the Oasis Beach Pool are all easy going, non-vigorous swimming sessions aimed at older clients.
 - Aquatone and Aquacise at Kempston Pool and Aquarobics at the Oasis Beach Pool are water workout sessions which are ideal for older people.
 - The Deep Water Work-Out at Robinson Pool provides water aqua-aerobics with the support of buoyancy aids and this is aimed at older age group.

- Ladies Leisure at Oasis Beach Pool; Ladies Learn to Swim at Kempston Pool and Ladies Lessons at Robinson Pool all provide swimming, instruction and water based exercise for 50+ Ladies.
- Ladies Recreation at Bedford International Athletic Stadium offers a fitness class and the opportunity to play badminton or workout in the gym, ideal for the older age group.
- 50+ Low Impact Aerobics; 'Hips, Bums & Tums' and Body Conditioning at Robinson Pool are all aimed at older age group.
- General 50+ sessions for badminton, 50+ aerobics, short tennis, tennis and table tennis are held at Bedford International Athletic Stadium and the Bunyan Sports Centre.
- 'Zumba' at Bedford International Athletic Stadium, the Bunyan Sports Centre and Robinson Pool all offer easy to follow, calorie burning and fun based dance routines ideal for the older age group.
- Off-peak pricing at gyms, aimed at older people, 30% of gym members are over 50 year of age.
- The Bunyan Sports Centre now has day-time availability as the Academy has moved into its new building and the Centres programme is under review with opportunities for new activities for older people to be based there.
- The Inclusive Fitness Initiative Gym at Robinson Pool has equipment specially designed for users with a disability.
- REActive8 Gold – 50+ group – current activities include TAI CHI; swing dance; tennis; pilates; indoor bowls; golf; swimming and badminton.

3.79 A number of gentle exercise classes/programmes take place throughout Bedford and the 'Walk with Me' programme is aimed specifically towards the frailer older person who is accompanied by a volunteer 'buddy'.

3.80 The annual "Community Dance Festival" with around 1500 visitors that is run by the Sports Development Team attracts a large number of older residents and helps offer non sporting physical activity options to people who wish to become more active.

3.81 Across the all activities which help to alleviate loneliness, good practice will continue to be embedded in relation the selection and training of volunteers and on-going support and encouragement for participants to stay engaged. We will continue to consult and engage older people in the design, delivery and review of projects ensuring they are built on their needs and interests.

Fuel Poverty

3.82 A fuel poor household is one that needs to spend more than 10% of its income on fuel use to have the home at an adequate standard of warmth (defined by the World Health Organisation as 21°C in the living room and 18°C in the other occupied rooms). It is estimated that 15.1% of Bedford Borough's households are fuel poor (Source: DECC Sub-Regional Fuel Poverty Data 2010)

3.83 Fuel poverty is identified in our Joint Strategic Needs Assessment as a key issue in the Borough, "particularly among those living in owned and private rented

accommodation and among older people.” 15.1% of Bedford Borough's households are fuel poor, a figure that has increased over the last 3 years and is likely to increase further.

- 3.84 Households of one person aged over 60 or older couples with no children living in the family home are more likely to be in fuel poverty than either couples or larger families. Other vulnerable groups include families with young children and the long term sick and disabled. These groups typically spend a higher proportion of their time at home, using more fuel to heat their homes for longer.
- 3.85 There is a higher risk of fuel poverty in rural areas. This is due to properties on average being larger and less energy efficient (*many of these properties having solid walls which are difficult and more expensive to insulated or being off the gas network to heat more efficiently*), and the impact of lower average temperatures in the countryside. Combining the risk factors means older people on low incomes in rural areas are especially at risk.

Warm Homes, Healthy People

- 3.86 Following successful use of a similar grant over the winter of 2011/12 the Council is again leading a group of local community organisations deliver a programme to help vulnerable people stay warm in Bedford Borough. Bedford Borough Council made the grant application in partnership with Bedfordshire Rural Communities Charity, Bedfordshire & Luton Community Foundation, Age UK Bedfordshire, Bedford & District Citizens Advice Bureau, Bedford Race & Equalities Council and Salvation Army Bedford.
- 3.87 Delivery is through 4 strands co-ordinated by the project team.

1. Awareness

- Partners will target neighbours and family members as well as vulnerable people themselves, encouraging people to take action against cold weather, providing advice and signposting to sources of support. This builds on the work of Big Energy Saving Week (end of October) that a number of the partners were involved with.

2. Prevention

- Outreach and identification of vulnerable people and families across the Borough by front-line workers across all partner organisations (e.g. social workers, health workers, Village Agents, community support workers, street rangers).
- All partner organisations provide information and advice services, including grants/benefits available (e.g. Energy Company Obligation; rebates on fuel bills; Warm Front); energy efficiency; switching suppliers in order to decrease energy costs; and signposting to other sources of advice or practical support as appropriate (e.g. provision of low-level insulation equipment).
- Comprehensive energy audits for 200 households most vulnerable to rising fuel prices, cold temperatures and energy inefficient homes (such as the elderly, disabled and those with young children or an illness) – referrals for energy

efficiency improvements to be made either to national funded schemes or to Bedford Borough Council schemes such as the Home Improvement Grant.

3. Crisis response

- Provision of warm meals, clothing/equipment and other means of increasing warmth to the most vulnerable residents (such as the elderly, disabled and those with young children or an illness) by voluntary organisations and community groups (e.g. care schemes, lunch clubs and churches).
- Other practical support to vulnerable people, e.g. door to door transport to shopping, day services or GP appointments; picking up shopping; dog walking; snow clearing.
- Salvation Army Night Cafe is able to extend its opening hours to open any night when temperature is 0 degrees or less (without the grant could only open when -3 degrees or less).

4. Resilience

- National Energy Action are providing fuel poverty training to 20 frontline home visiting staff (others have already received similar training through other projects), enabling them to identify fuel poverty and excess cold, give basic advice on improving affordable warmth and signpost to other services including the energy audits and further support from the Council and external partner agencies.
- Debriefing meeting for local agencies with an action plan to take learning and development forward.

Falls

- 3.88 Falls are a major cause of disability and the leading cause of mortality resulting from injury in people aged 75+ in the UK. They represent a major public health challenge as they lead to injury requiring high-cost, unscheduled care and often result in the need for ongoing care and support.
- 3.89 Approximately 35% of people aged 65 years and over living in the community are likely to fall at least once a year, and this increases to almost double in those aged over 80 years (DoH, 2009). Half of fallers are likely to have a further fall within the next 12 months.
- 3.90 Falls are not an inevitable result of ageing and although most falls do not result in serious injury, the consequences of falling, or of not being able to get up after a fall, can be devastating. Consequences can include:
- Fear of falling and loss of confidence to move around safely
 - Loss of mobility, leading to social isolation and depression
 - Increase in dependency and disability
 - Hypothermia
 - Pressure related injury
 - Infection
- 3.91 The major risk factors for falling include poor balance, muscle weakness, medication and environmental hazards and the risk of falling increases with the number of risk factors. Therefore falls prevention interventions must be multi-

factorial and include exercise, education, medication reviews and environmental assessments and modifications, if required.

- 3.92 In 2012, an estimated 7,156 people aged 65 and over are predicted to have a fall in Bedford Borough (POPPI, 2012). However it is important to note that this is the number of people and not the number of falls which is likely to be considerably higher given that approximately half of these people will go on to have multiple falls.
- 3.93 In 2010/11, there were 2,137 hospital admissions for falls (per 100,000 people aged over 65 years) and 142 hip fractures in Bedford Borough. Nationally, the incidence of falls is increasing at around 2% per annum and this is expected to continue as the population ages (DoH, 2009).
- 3.94 Osteoporosis weakens bone strength and an estimated one in three women and one in twelve men over 50 are affected by it. Almost half of all women experience an osteoporotic fracture by the time they reach the age of 70.
- 3.95 Fractures among the older population typically result from a fall from standing height. A hip fracture remains the most common cause of accident related death, with a 20% mortality rate within 4 months and a 30% mortality rate within a year (DoH, 2009).
- 3.96 Approximately half of those people who were previously independent become partly dependent following a hip fracture, with one third becoming totally dependent. An estimated 10% of older people that suffer a hip fracture are likely to require admission to a care home as a result of their injury (DoH, 2009). A number of initiatives to prevent fall are in place and these will continue to be monitored for effectiveness.
- 3.97 **The Falls Group Pilot**, based in the Mulberry Unit, Bedford Hospital. Bedford Borough residents aged 65 and over who have fallen in the past 12 months or are at high risk of falling, are invited to attend a multifactorial falls prevention programme (subject to criteria).
- 3.98 **First Response Service Pilot**, currently operates Monday to Friday. The team responds to 999 calls to people that have fallen but are medically stable. They provide an assessment, equipment and ensure the persons' social care needs are met.
- 3.99 **Fracture Liaison Service Business Case**, in development. A fracture liaison service is a multi-disciplinary service that assumes responsibility for the secondary prevention of osteoporotic fractures through assessment, diagnostic evaluations and treatment. It focuses on patients with new fragility fractures and those who have fractured in the past or are at risk of osteoporotic fractures in the future.
- 3.100 **Falls Awareness and Information Pack for Care Homes**: draft pack developed for use in both residential and nursing homes. Contents include risk assessment and checklists, post fall assessment, root cause analysis and information.
- 3.101 Research shows that residents living in care homes have a higher rate of falls than community dwelling older adults. The **Complex Care Team** supports nursing and residential homes to reduce avoidable hospital admission rates.

- 3.102 Following a successful pilot, the programme was extended to all care homes across Bedford Borough. Outcomes from the 6-month pilot included a:
- 25% reduction in A&E attendances
 - 38% reduction in emergency admissions
 - 50% reduction in GP out of hours visits
 - Reduction in GP visits
 - Reduction in the number of medicines prescribed – a conservative estimated saving of £15,600

Reablement and Assistive Technology

- 3.103 The Council Reablement Team prevents hospital or care home admission and delivers post hospital discharge care. They also aim to improve function and level of independence through the provision of reablement focussed support to people in their own home. Typically, treatment lasts 6 weeks and makes use of assistive technology.
- 3.104 Technology offers real potential for supporting older people to stay in their own homes. Simple gadgets can make all the difference to a persons comfort and feeling of security. Assistive technology covers things like door alarms, pressure mats and room monitors as well as outsize remote controls and devices to help in the kitchen that all help older people to maintain their independence.
- 3.105 Telecare is provided at a distance using information and communication technology, involving the continuous, automatic and remote monitoring of real time emergencies and lifestyle changes over time in order to manage the risks associated with independent living. Telecare can give older people and carers more personal freedom and time to concentrate on the human aspects of care and support as well as making a contribution to meeting potential shortfalls in the workforce.
- 3.106 The telecare service specification has improved. Now there is a response service for people who do not have relatives or friends who can quickly and reliably attend when an alert happens. There will also be a new proactive calling service, which will be able to telephone people reminding them to take their medication or switch the heating on in bad weather.
- 3.107 Telehealth is monitoring vital signs like blood pressure, and transmitting information to a response centre, where the results can be reviewed by a clinician. A successful telehealth pilot was carried out in the Central Bedfordshire area and the CCGs intention is to roll the service out across the whole Bedfordshire area. The Council and the CCG's ambition is to eventually integrate telecare and telehealth.

Health and Wellbeing

- 3.108 Everyone in the Borough has an equal right to good health. It is our vision to enable all our residents to lead healthy lives by providing the support and opportunities which they need to do this. The health of people in Bedford Borough has improved over recent years: death rates from cancer, heart disease and stroke have fallen, and there has been a decline in the number of adults who smoke, which is now lower than the national average. However, we see a widening gap in

life expectancy between the most and least deprived areas and there is still much room for improvement. There is a separate Health and Wellbeing Strategy which identifies our top immediate priorities for promoting health and wellbeing in the borough. Although these will be the main focus for the Bedford Borough Health and Wellbeing Board, they have been selected from a longer list of priorities, all of which will be monitored by subgroups for child and adult health and wellbeing.

3.109 The priorities are summarised in the table below:

OUTCOMES

CHILDREN	Teenage Pregnancy		We will reduce the number pregnancies in young women aged under-18 and improve outcomes for teenage mothers.
	Looked After Children		We will improve the health and educational outcomes of looked after children through high quality health, and social care support.
	Mental Wellbeing		We will improve mental health in children and adults by providing high quality, effective services which identify mental disorders and intervene early.
	Healthy Lifestyles: Tobacco Control Alcohol Consumption Healthy Weight		We will further reduce smoking prevalence by preventing people from starting to smoke and helping people to stop smoking. We will promote sensible drinking and increase the number of people receiving effective and timely support for alcohol related problems. We will maintain or increase the number of people who are a healthy weight, by providing a range of evidence based interventions.
	Safeguarding		We will safeguard children by introducing multiagency early interventions (tbc) We will safeguard adults through elimination of maltreatment, neglect and abuse, including prevention of avoidable pressure ulcers.
	Wider Determinants of Health		We will address wider determinants of health focusing on educational attainment, reducing the number of people who are fuel poor, and those young people who are not in education, employment or training.
	Independence	ADULTS	We will maximise independence in older people by improving stroke care and rehabilitation services, preventing falls and reducing preventable hospital admissions.

	End-of-Life Care		We will provide high quality care and support for people at the end of their lives and their carers, including increasing choice and control over where people wish to die.
CROSS-CUTTING PRINCIPLES FOR ALL SERVICES EQUITY – ACCESSIBILITY – INTEGRATION – EFFECTIVENESS – SUSTAINABILITY- SAFEGUARDING			

3.110 For much more detail please read the Bedford Borough Health and Wellbeing Strategy.

3.111 Two Health Trainers are commissioned by the BCCG for the Bedford Borough area. The Health Trainers undertake individual assessments and work with people at a greater risk of poor health, on a one-to-one basis. Health Trainers provide individual support and advice to help people to identify and achieve their own health goals and to make healthier lifestyle choices. The four areas in which Health Trainers most often provide support are diet, exercise, alcohol and smoking.

Information Advice & Guidance

3.112 Older people in the Borough frequently raise the issue of improving information, advice and guidance.

3.113 When there is a lack of clear information available about care services, individuals can easily become disempowered. Our consultation with older people would suggest this process also applies to more mainstream services like adult education, leisure opportunities, benefits, and transport as well as social care services.

3.114 Providing improved information, that informs, assists and support older people to access universal and specialist services and to enable them to increasingly participate in the life of their communities, is therefore a 'must do'. In the last couple of years a great deal of information advice and guidance has been placed on the Council and NHS web-pages. A key task now is keeping track of what is there and making sure it is all kept up to date. For those people who do not use the internet then alternatives need to be kept in place such as paper directories and telephone advice lines as well as personal access to some of the many information advice and advocacy providers in the local area.

3.115 Local third sector organisations play a key role in providing information and advice to older people on a whole range of topics including benefits; finance; health and wellbeing; help to stay living at home and housing. Some key local providers of information and advice for older people are:

- Advocacy for Older People, Tel: 0300 456 2362 (local rate call)
- Age UK Bedfordshire, Tel: 01234 360510
- Bedfordshire and Luton MIND, Tel: 0300 330 0648
- Carers in Bedfordshire, Tel: 0300 111 1919
- Citizens Advice Bureau – Bedford and District, Tel: 0844 245 1290
- Healthwatch Bedford Borough Signposting Service, Tel: 01234 866477
- Just Ask-Village Agents, Tel: 0800 039 1234 (Freephone)

3.116 An annual ageing well exhibition takes place which is an opportunity for older people in Bedford Borough to find out what services and opportunities are available to them. Typically around 45 organisations and services attend the exhibition. They provide information on what support there is to enable people to remain independent and make choices about what services to access.

Our Commitments

Strategic Priority 2: Delaying and reducing the need for care and support.

We will:

1. Implement the Older People's Accommodation Strategy
2. Undertake a tendering exercise for the 6 Council owned registered care homes
3. Conduct a Community Beds Review in partnership with BCCG and make recommendations
4. Respond to the Supporting People Strategy Consultation and produce a final version of the Strategy
5. Take action to combat Fuel Poverty by implementing the Warm Homes Healthy People Programme for as long as funding is made available.
6. Take action to reduce the number of older people being injured through falls.
7. Review the 'health' Rehabilitation & Enablement and the 'social' reablement teams and identify opportunities for more effective use of resources such as one team with joint social care and health performance indicators eg Accident and Emergency attendances and care home admission reduction. They should deliver a strategy to match the national best rate of reablement within three years.
8. Develop a residential reablement service.
9. Increase the use of Telehealth, where people can take readings of vital signs such as heart rate in their own home and send the results sent to a website for review by health professionals who take action when necessary, and work together to integrate telecare and telehealth provision.
10. Increase numbers of people aged 50+ participating in sport and physical activity.
11. Support voluntary and community groups in the Borough that provide activities for older people e.g. social clubs, lunch clubs, day services, educational opportunities, village help and community transport schemes.
12. Take action to support Government's target to eradicate fuel poverty as far as reasonably practicable, by 2016.

Strategic Priority 3: Ensuring that older people have a positive experience of care and support

Personal Budgets and Direct Payments

3.117 Older people should have maximum greater control over how their needs are met. The take up of Direct Payments by older people in the Borough is helping to maximise the effective use of personal budgets.

3.118 Everyone eligible for services is informed what their personal budget is and can take some or all of it as a direct payment. They can, with support if they want it, direct how their personal budget is used to meet their needs.

- 3.119 Personal Health Budgets: Following a three year pilot of personal health budgets, with NHS Bedfordshire as an in-depth evaluation site, it has been announced that from April 2014, anybody eligible for NHS Continuing Health Care will be entitled to request a Personal Health Budget. This is a mandatory obligation of Clinical Commissioning Groups going forward. A personal health budget is an amount of money that is spent on meeting the health care and wellbeing needs of people who meet the eligibility criteria for NHS Continuing Health Care.
- 3.120 At the heart of a personal health budget is a care plan (sometimes known as a support plan or personal health plan), which is developed with individuals in partnership with their health care professionals. The plan sets out the individual's health care and wellbeing needs, the health outcomes desired, the amount of money in the budget and how this will be spent.
- 3.121 Personal Health Plans give people more choice about their care by providing information on a range of options for managing their condition, including a greater focus on self-care. Plans are optional for people with long term conditions and designed to be flexible. They encourage discussions about their wider health and wellbeing needs and help them to choose services which meet their individual needs rather than simply those that practitioners recommend. As Personal Health Budgets are developed and offered to individuals with conditions outside of Continuing Health Care, Personal Health Plans will form the basis of personalising the care and enabling individuals to purchase their own health interventions that best meet their needs.

Advocacy, Information and Advice

- 3.122 Older people can access printed and web based versions of leaflets about Adult Services and a whole range of supporting information including directories of local private and charitable sector services . In addition NHS Choices for All and the Lifestyles Directory provides access to advice and information about health and wellbeing, local programmes and activities. Information is available in large print, different languages and in a range of formats.
- 3.123 For many older people, their first contact with a local authority service will be at a time of stress or crisis. Advocacy services (where an advocate communicates and supports the service user's wishes) are invaluable at this time. Advocacy supports people in making their own decisions and ensures that their views are properly represented. Advocacy for Older People is working in partnership with POWhER to deliver advocacy locally. The contract with the two organisations started in October 2011 and provides advocacy for a growing number of people.

Extra Care Housing

- 3.124 The role of Extra Care housing in providing an effective alternative to residential care is a major part of our vision for the future. Extra Care housing can be owned, rented, part owned and part rented or leased by the person living there. Extra Care schemes come in a range of models and are often designed like a small 'village' for older people with on-site services like shops, library, health workers and social activities. Alternatively, they can be relatively small housing schemes with onsite care and communal facilities such as lunch services, laundry, common rooms, IT suites and day activities. The smaller schemes tend to meet the needs of people

with higher care needs. Care villages tend to have a higher proportion of people with no care needs but amongst a wider overall mix of different care needs.

- 3.125 Extra Care schemes have design features that promote independent living and help older people to self-care for longer. The best Extra Care schemes also play an active role in their local communities. They provide a base for intermediate care, rehabilitation services, day activities, keep fit, floating support for older people living nearby who need help and support, and for community based teams of domiciliary care and health workers providing therapy and nursing.
- 3.126 There are different models of extra care housing but a typical scheme could be 40 to 60 one or two bed-roomed apartments with onsite care and a range of supported communal facilities including an onsite ability centre, activity rooms, library, fitness suite, and restaurant, all of which can by arrangement be accessed by the local community. The village model provides a mix of apartments and bungalows as well as extensive communal facilities. A feature of any Extra Care scheme is the flexibility of the care provided and the concept of the mixed tenure options. In the last year Gordon Colling House has opened and we have remodelled Tavistock Court and Dame Alice Court to provide Extra Care Housing. St Bedes is currently being built near Bedford town centre and this will offer a over 100 units with on-site facilities and a mix of properties for rental and shared ownership.
- 3.127 We are reviewing the need for any more Extra Care places over the next three years, and will work with the housing associations and other suitable organisations to make best use of what we have, including .people with higher care needs who would otherwise be moving in to institutional care.

My Home Life; Implementing Quality of Life in Bedford Care Homes

- 3.128 My Home Life is a UK-wide charitable initiative promoting quality of life for older people living and dying in care homes, and for those visiting and working with them. It is led by Age UK in partnership with City University and the Joseph Rowntree Foundation.
- 3.129 My Home Life have worked with over 60 academic researchers across the UK to develop an evidence base for quality of life in care homes. The review of evidence explored ‘what residents want from care homes’ and ‘what practices work in care homes’.
- 3.130 The evidence was found to cluster around 8 best practice themes:

1. Managing Transitions

Supporting people both to manage the loss & upheaval associated with going into a home and to move forward.

2. Maintaining Identity

Working creatively with residents to maintain their sense of personal identity and engage in meaningful activity.

3. Creating Community

Optimising relationships between and across staff, residents, family, friends and the wider local community. Encouraging a sense of security, continuity, belonging, purpose, achievement and significance for all.

4. Sharing Decision-making

Facilitating informed risk-taking and the involvement of residents, relatives and staff in shared decision-making in all aspects of home life.

5. Improving Health & Healthcare

Ensuring adequate access to healthcare services and promoting health to optimise resident quality of life.

6. Supporting Good End of Life

Valuing the 'living' and dying' in care homes and helping residents to prepare for a 'good death' with the support of their families.

7. Keeping Workforce Fit for Purpose

Identifying and meeting ever-changing training needs within the care home workforce

8. Promoting a Positive Culture

Developing leadership, management and expertise to deliver a culture of care where care homes are seen as a positive option.

3.131 Together these themes offer a vision for care homes to deliver quality of life.

3.132 The vision is underpinned by 'relationship-centred care' that recognises the importance of seeing the care home as a community where the quality of life of staff, family, friends and residents are all crucial to improvements in practice.

3.133 Implementing the My Home Life programme in Bedford Borough has involved two parallel strands of work

- Transforming care home managers
- Influencing work with the wider health & social care system.

3.134 This will ensure that the work has a real impact on the culture of practice in both care homes and the wider system to ensure quality of life of care home residents, relatives and staff. Particular emphasis will be given to supporting a 'voice, choice and control' for older people with complex health needs, including those with dementia.

3.135 A launch event brought managers together to hear about the evidence for quality of life in care homes, share good practice ideas, communicate where care homes need more support and find out more about what is on offer to them through the My Home Life programme.

3.136 Over a 14 month period we are offering a group of managers leadership and support through an intensive learning package, followed by action learning sets to support their journey of 'culture change' in moving towards the evidence-based and relationship-centred vision of My Home Life.

- 3.137 The 'community development' element of the package involves meeting with a range of stakeholders not just from the care home sector, but also, from the local community and wider health & social care system, such as NHS commissioners, regulators, Bedford Hospital, GPs, social workers, churches, geriatricians, community nurses and volunteers.
- 3.138 Ultimately, this work is about fostering more positive relationships between care homes and the community/health and social care system to the benefit of the residents and relatives.
- 3.139 A final event will be held, hosted by My Home Life and Bedford Borough Council inviting a range of participants to share and celebrate their learning from the programme. Information will be captured to measure the outcomes of the programme. This will enable members of the manager's leadership group to encourage other managers to take forward learning from the programme and leave a lasting legacy.

Palliative Care and End of life care

- 3.140 Palliative care is care that helps all those with advanced, progressive, incurable conditions to live as well as possible until the very final stages of their lives. End of life care is care and support that helps people who are dying to have the choice of where they die and support to have a 'good' death. End of life planning enables the supportive and palliative care needs of both patient and family to be identified and met through the final phases of life and into bereavement.
- 3.141 It includes physical care, management of pain and other symptoms, and provision of psychological, social, spiritual and practical support.
- 3.142 It is underpinned by an active and compassionate approach to care that ensures respect for dignity for the person and family.
- 3.143 The care that people have told us they would like at the end of their life includes:
- more choice
 - better quality
 - integrated services which are co-ordinated across all care settings e.g. at home, hospital, hospice and care homes
 - more support for care
 - specialist training for staff
 - availability of co-ordinated emergency and 24/7 care
 - continuity of care
 - good transport to out-patients
 - specialist inpatient beds
 - more information about bereavement services
 - access to a choice of services that give unpaid carers a break from their caring role
- 3.144 We are working with partners to implement the Gold Standards Framework (2006), improving palliative care in the community. This is a multi-disciplinary team approach that identifies patients at the end of their life, assesses their care needs and plans care appropriately.

- 3.145 We are also working with partners to implement the Liverpool Care Pathway for the final three days of life, providing co-ordinated end of life care that gives people and their families as positive experience of the death as is possible.
- 3.146 We have set up a 24/7 co-ordination hub for people with palliative care needs and people who are at the end of their lives based at St John's Hospice. This means that people in the final six months of their lives and their families can ring for support at anytime. This helps people to remain at home, well supported and confident that if they need help, they will get it.
- 3.147 Our target is to support as many people as possible to choose their place of death and to be able to die there comfortably and peacefully. For a lot of people, this will be their own home, and for a few it will be a care home. By providing access to support when its needed, more people will be able to die at home instead of in hospital.
- 3.148 The Joint End of Life Strategy has a number of work streams with action plans including Adult Social Care. Bedford Borough Council has committed to delivering:
- Care home contracts that require care homes to support people to stay there to die if that is their wish
 - Contracts with domiciliary care providers that require them to train staff that are competent to deliver palliative care and end of life care
 - Contracts with care and support providers who deliver on site care in extracare settings to provide palliative care and end of life care, including breaks for carers by providing care workers who can step in for a few hours while the carer takes a break.
 - Support after someone has been diagnosed with a life limiting condition for end of life planning.
 - Support for former carers after a bereavement, to come to terms with their loss and to help them move forward in their lives.
 - Speedy access to equipment, telecare and aids and adaptations.

Our Commitments

Strategic Priority 3: Ensuring that older people have a positive experience of care and support

We will:

1. Engage older people in all parts of the Borough with a planned programme of activities and consultation.
2. Enable older people and carers to have choice and control over their care and support and the resources that pay for it.
3. Improve the range and quality of information, advice and advocacy services available to older people and, in particular, to people who are 'hard to reach'.
4. Ensure everyone with end of life care needs is identified and their needs assessed.
5. Ensure that unpaid carers are identified when the person with care needs is assessed, and ensure that the unpaid carers are referred to appropriate help, such as Carers in Bedfordshire and the Council's Adult Services.
6. Ensure sufficient capacity and quality of home care providers including providers

who can meet end of life needs.

7. Ensure that staff delivering care in all settings (home, extracare and in care homes) are competent to deliver care to people at the end of their lives.
8. Improve quality of care in local care homes by implementing the 'My Home Life' programme.

Strategic Priority 4: Safeguarding older people whose circumstances make them vulnerable and protecting them from avoidable harm.

Safeguarding from abuse, maltreatment and neglect.

- 3.149 Safeguarding vulnerable adults from abuse, maltreatment and neglect is our number one priority. It is a vital part of the council's core responsibilities and also an essential function of health services.
- 3.150 Abuse comes in many forms – physical, sexual, psychological, financial, neglect or discriminatory abuse. Institutional abuse happens in services where poor care is delivered. These forms of abuse can be deliberate or the result of ignorance, lack of training, non compliance or management oversight.
- 3.151 Safeguarding is about more than just adult protection, it is about enabling vulnerable people to choose lifestyles and services to support their needs which ensures their independence, health, safety and wellbeing. Services need to deliver flexible support based on the principles of human rights, dignity and independence.
- 3.152 Safeguarding is “all work which enables an adult who is or may be eligible for community care services to retain independence, well being and choice **and** to access their human right to live a life that is free from abuse and neglect”

*Safeguarding Adults, A national framework of standards for good practice and outcomes in adult protection work
ADASS 2005.*

- 3.153 ADASS outlined its vision for safeguarding adults in April 2012 (Safeguarding Standards and Performance)

"Our vision is that Safeguarding Adults Boards or Partnerships lead work in our communities to ensure that for adults who are at risk, or in vulnerable situations, the agencies who support them and the wider community together can:

- develop a culture which does not tolerate abuse:
- raise awareness about abuse:
- prevent abuse from happening wherever possible:
- support and safeguard the rights of people who are harmed to stop abuse continuing, access services they need including advocacy and post abuse support and have improved access to justice.

- 3.154 Safeguarding across Bedford and Central Bedfordshire is monitored by the multi-agency Safeguarding Adults Board. Membership includes service users and carers alongside key statutory, voluntary and private providers.

3.155 The Safeguarding Adults Board sets priorities for improvement in policy, practice and performance. It continually strives to reduce the occurrence of abuse by taking a 'lessons learnt' approach to prevention. A detailed improvement action plan is in place and regular monitoring reports will continue to be provided to the Board.

3.156 The current key priorities for the Safeguarding Adults Board are;

- To improve safeguarding practice as a result of independent audit and Peer Review
- To improve our approach to learning and development
- To review and address the reasons for the high volume of alerts received which do not require a formal investigation, the low number of alerts relating to hard to reach communities and the low level of alerts from the general public
- Safeguarding and the role of informal carers
- The vulnerability of people with disabilities to abuse and harassment
- Review the quality of services for people with learning disabilities.

Community Safety

3.157 For many older people, having a sense of wellbeing and a good quality of life is directly connected to living in a safe community and having a sense of security in their own homes. Older people regularly confirm 'feeling safe in my community' as a top priority.

3.158 The Council has established and supports the operation of a Borough-wide Community Safety Partnership (CSP) involving a range of service providers, including Police, Probation and Fire and Rescue. The CSP is responsible for reviewing the community safety needs of the Borough and producing a community safety plan, which targets action at priority community safety issues. The current plan, 2012-14, includes actions to tackle anti-social behaviour (ASB) and increase security and safety of vulnerable people in their own homes and local neighbourhoods. The Council's Community Ranger and ASB services play a crucial frontline role working with partners, victims and offenders and the wider community to deliver these actions on the ground.

Bogus Callers & Approved Tradesmen Schemes

3.159 Since becoming a Unitary Authority, Trading Standards functions have integrated into the Commercial Regulation team to provide an improved multidisciplinary service. This serves to maintain its links with key partners by utilising local intelligence to support vulnerable people and target intervention strategies towards bogus callers. The newly integrated team continues to provide a fast response service, respond to requests for assistance and offers comprehensive advice and support to those most in need within our society.

Meeting The Dignity Challenge

3.160 The Dignity Challenge is a national initiative to improve dignity in health and social care services. It provides a clear statement of what people should expect from a service that respects their dignity, backed up by a series of 'dignity tests'. These dignity tests will be implemented in Bedford Borough by providers, commissioners and people who use services to see how their local services are performing.

- 3.161 Dignity Action Day is an annual event aimed at encouraging all health and social care workers to promote dignity in their place of work, it forms part of the work of the Dignity in Care campaign.
- 3.162 The campaign's core values are about having dignity in our hearts, minds and actions, changing the culture of care services and placing a greater emphasis on improving the quality of care and the experience of citizens using services including NHS hospitals, community services, care homes and home support services.
- 3.163 To support staff working in Adult and Community Services to deliver quality services that embrace dignity we will launch a new project on dignity Action Day 2013, 'Meeting the Dignity Challenge'.
- 3.164 The directorate will focus on one of the 10 dignity tests each month. Each team will identify what they do well and what they can do to improve their services in order to meet that month's challenge. Each month the teams will complete a template recording 'what they do well' and 'what they could do better' and report to the 'Adult Service Performance Clinic' as a regular agenda item.
- 3.165 Meeting the Dignity Challenge will encourage staff to share their good practice with others and continuously strive to deliver services that embody 'dignity'. At the end of the 10-month project, all the information will be collated and a review conducted to see what improvements have been made.

Patient Led Assessments of the Care Environment (PLACE)

- 3.166 On 6th January 2012, the Prime Minister announced a renewed drive 'to ensure that every patient is cared for with compassion and dignity in a clean environment'. Patient-led assessments of the hospital environment were announced. The Prime Minister's statement confirmed that these new assessments would see local people go into hospitals as part of teams assessing privacy and dignity, food, cleanliness and facilities management.
- 3.167 The assessments have patients' views at their heart from concept to delivery. The focus will be much more strongly on what patients think and feel, looking at what matters to them, and seeing it through their eyes. We are committed to strengthening patients and users' ability to exercise extended choice and to have their voice heard.
- 3.168 The new PLACE assessments will replace the current Patient Environment Action Team (PEAT) inspections, in hospitals offering NHS-funded care, hospices and Independent Treatment Centres from April 2013.

Our Commitments

Strategic Priority 4: Safeguarding older people whose circumstances make them vulnerable and protecting them from avoidable harm.

We will:

- Protect people from discrimination or harassment due to their age, ethnicity, gender,

- physical disability, learning disability, mental ill-health, sexuality or any other cause.
- Promote Neighbourhood Watch to prevent crime, help with crime detection, reduce undue fear of crime and improve police and community relations.
 - Improve public awareness of the need to safeguard vulnerable people.
 - Develop home safety services.
 - Work with partners to reduce crime and increase public confidence that police are dealing with issues in local communities.
 - Promote to older people the Council's 'Trusted Traders' scheme which accredits services such as housework, shopping, locksmiths and plumbers.
 - Implement and keep under review the joint strategy for the Safeguarding of Vulnerable Adults with partners.
 - Improve advocacy for people in care homes and extracare settings.
 - Ensure specialist support is available out of hours for service users and carers living in the community.
 - Do 'Meeting the Dignity Challenge' to ensure Adult and Community Services:
 - 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.
 - Put in place the new PLACE assessments to replace the current Patient Environment Action Team (PEAT) inspections, in hospitals offering NHS-funded care, hospices and Independent Treatment Centres from April 2013.

This is the Joint Commissioning Strategy for Older People Strategic Action Plan. It is reviewed annually to incorporate any changes to government policy and local priorities.

Joint Commissioning Strategy for Older People Strategic Action Plan

Strategic Priority 1: Enhancing quality of life for older people with care and support needs.	Objectives	Due date	Responsible
1. Ensure Healthwatch Bedford Borough is successfully launched and integrated into the local system during 2013.	1. Launch Healthwatch Bedford Borough 2. Ensure Signposting and ICAS functions properly commissioned 3. Raise public awareness 4. Review and plan for 2015 onwards	April 2013 April 2013 October 2013 June 2014	Head of Commissioning (GH)
2. Adult services will work with Highways in the context of the local transport plan to better understand trips and falls in the streets and identify what can be done to reduce them within resources.	1. Review Highways information on trips and falls 2. Estimate costs of trips and falls 3. Identify opportunities to reduce trips and falls within resources.	June 2013 October 2013 December 2013	Senior Network Policy Officer (SD) Public Health Manager (JG)
3. Encourage, support and enable clients to use public transport rather than day services transport.	1. Maintain concessionary travel for older people. 2. Identify barriers to use of public transport versus day services transport for older people. 3. Make recommendations to remove barriers as far as practically possible 4. Design transition plan to ensure use of public transport is optimised and day services transport minimised.	April 2013 October 2013 December 2013 January 2014	Senior Network Policy Officer (SD) Service Manager for Older People (JS)
4. Increase volunteer engagement in the management and promotion of Council owned parks and amenity green spaces.	1. Launch pilot Park Champion scheme at several targeted sites. 2. Evaluate and subject to findings, roll out Borough wide 3. Support development of Priory Country Park conservation volunteer group into	April 2013 April 2014 April 2014	Head of Communities (JC)

	fully constituted Park Friends Group.		
5. Increase older peoples' access to the rights of way network by removing barriers and improving structures.	1. Remove 30 stiles or upgrade 30 existing gate structures to easy access standard on rights of way in 9 targeted parishes	April 2014	Head of Communities (JC)
6. Improve older people's health and well being through development and promotion of opportunities for outdoor exercise.	1. Work with Sports Development and Public Health to trial development and promotion of adult outdoor 'gym' fitness programme in Jubilee Park. 2. Work with Public Health to support expansion of volunteer led health walk scheme.	October 2013	Head of Communities (JC) Public Health Manager (JG)
7. Increase volunteer engagement to assist the Council with rights of way survey, maintenance and promotion works.	1. Recruit, train and mobilise volunteers to report rights of way problems and undertake basic routine maintenance tasks across the Borough	April 2014	Head of Communities (JC)
8. Review the support available to older employees in the Council.	1. Review key policies and procedures to ensure no age discrimination 2. Review flexible working and phased retirement procedures 3. Review support available to Carers	April 2014	Head of HR Operations (KJ) Head of Commissioning (GH)
9. Monitor the effectiveness of the newly commissioned welfare rights services from Citizens Advice Bureau	1. Quarterly contract review meetings 2. Benchmarking against previous levels of service 3. Refine service specification based on reality of delivery	June 2013 October 2013 April 2014	Commissioning Officer
10. Ensure older people and carers help decide what services should be provided, how they should be delivered and how well they are being delivered.	1. Review membership of Older People's Partnership Board to ensure it is appropriate 2. Consult through the Board and partner organisations on all changes to policy and services 3. Further develop older people's involvement in the 'mystery shopping' programme.	June 2013 Continuously October 2013	AD Community Care Services (JB) Personal Budget Support Officer (AH)

11. Increase the number of older people who are volunteers, especially from 'hard to reach' groups.	1. Review scope of volunteer activity in Adult Services and Health	June 2013	Personal Budget Support Officer (GA)
	2. Identify where it can be increased and/or enhanced	October 2013	
	3. Design a programme to attract more older people to be volunteers	December 2013	

Strategic Priority 2: Delaying and reducing the need for care and support.	2013 - 2014 Objectives	Due date	Responsible
1. Implement the Older People's Accommodation Strategy.	1. Identify sites for the development of Extra Care housing units	October 2013	Head of Supported Housing (AK)
	2. Review sheltered housing stock for rent with landlords to identify potential schemes for decommissioning, or upgrading	December 2013	Head of Supported Housing (AK)
	3. Continually monitor the impact of extra care provision, reablement services, aids and adaptations, telehealth and telecare on the requirements for residential care provision and adjust the model for future needs accordingly.	April 2014	AD Community Care Services (JB) & Head of Commissioning (GH)
2. Undertaking a tendering exercise for the 6 Council owned registered care homes	1. Produce prospectus and open competitive tendering.	Complete	Head of Commissioning (GH)
	2. Undertake competitive dialogue to arrive at the most favourable service design.	October 2013	
	3. Award contract.	December 2013	
	4. Detail plan transition to new service configuration.	June 2014	
	5. Assuming planning and consultation requirements are met, commence service reconfiguration.	October 2014	
	6. Complete reconfiguration.	October 2015	

<p>3. Conduct a Community Beds Review in partnership with BCCG and make recommendations</p>	<ol style="list-style-type: none"> 1. Review all non-acute bed based social care and health services and identify how the system as a whole can function more effectively. 2. Produce a report with recommendations in an action plan. 3. Consult on the above. 4. Implement final action plan. 	<p>June 2013 October 2013 December 2013 April 2014</p>	<p>AD Business Support & Operational Housing (SW) e & Nisha Patel</p>
<p>4. Respond to the Supporting People Strategy Consultation and produce a final version of the Strategy</p>	<ol style="list-style-type: none"> 1. Collect all consultation responses 2. Review strategy in light of the above 3. Produce final version with action plan 	<p>April 2013 June 2013 October 2013</p>	<p>Head of Supported Housing (AK)</p>
<p>5. Take action to combat Fuel Poverty by implementing the Warm Homes Healthy People Programme for as long as funding is made available.</p>	<ol style="list-style-type: none"> 1. Bid for funds as they become available 2. Implement a co-ordinated programme of actions with partners to the programme 3. Ensure proper financial management of specific grant resources 	<p>October 2013 December 2013 March 2014</p>	<p>Head of Commissioning (GH)</p>
<p>6. Take action to reduce the number of older people being injured through falls.</p>	<ol style="list-style-type: none"> 1. Complete the Fracture Liaison Service Business Case 2. Roll out the Falls Awareness and Information Pack for Care Homes including risk assessment and checklists, post fall assessment, root cause analysis and information. 3. Monitor the effectiveness of the Complex Care Team in supporting nursing and residential homes to reduce avoidable hospital admissions. 	<p>June 2013 October 2013 April 2014</p>	<p>Public Health Manager (JG)</p>
<p>7. Review the 'health' Rehabilitation & Enablement and the 'social' reablement teams and identify opportunities for more effective use of resources such as one team with joint social care and health performance indicators eg Accident and Emergency</p>	<ol style="list-style-type: none"> 1. Agree terms of reference for review 2. Undertake review and provide report with recommendations 3. Consult and fine tune recommendations 4. Implement agreed actions 	<p>April 2013 June 2013 October 2013 April 2014</p>	<p>AD Community Care Services (JB) Nisha Patel</p>

attendances and care home admission reduction. They should deliver a strategy to match the national best rate of reablement within three years.			
8. Develop a residential reablement service within existing resources	<ol style="list-style-type: none"> 1. Partner identified (Charter House) 2. Agree admission criteria and pathway 3. Agree how outcomes will be measured 4. Implement service and monitor outcomes 	<p>April 2013 June 2013 June 2013 April 2014</p>	AD Community Care Services (JB) Commissioning Officer
9. Increase the use of Telehealth, where people can take readings of vital signs such as heart rate in their own home and send the results sent to a website for review by health professionals who take action when necessary, and work together to integrate telecare and Telehealth provision.	<ol style="list-style-type: none"> 1. Review Telehealth Strategy 2. Identify how Telehealth can best be used in the Borough 3. Identify opportunities for closer integration of Telecare and Telehealth provision 4. Produce joint Telehealth/Telecare strategy & procurement plan 	<p>June 2013 October 2013</p>	Head of Partnerships Commissioning BCCG (JH) Service Manager for Older People (JS)
10. Increase numbers of people aged 50+ participating in sport and physical activity.	<ol style="list-style-type: none"> 1. Deliver the annual programme of physical activity courses for over 50s 2. Deliver externally funded initiative of gentle exercise for over 70s. 3. Continue concession rates via the Bedford Leisure Card for the over 60's, people with a disability and those on a range of benefits. 4. Continue to offer a range of physical activities including the GP Exercise Referral Scheme (developed in partnership with NHS Bedfordshire) and Re-Active8 Gold which encourages older people to participate in physical activity. 5. Introducing new participants to activity prior to enrolment on pre paid courses via the 'pay on the door pre-Active8 	<p>April 2014 April 2014 April 2014 April 2014</p>	Head of Leisure and Culture (SD)

	initiative’.		
11. Support voluntary and community groups in the Borough that provide activities for older people e.g. social clubs, lunch clubs, day services, educational opportunities, village help and community transport schemes.	<ol style="list-style-type: none"> 1. Review funding to third sector 2. Ensure budget is focussed on priority areas 3. Support organisations to focus on outcomes 4. Monitor outcomes and make recommendations for any changes to specifications or contracts 	<p>October 2013 October 2013</p> <p>October 2013 April 2014</p>	<p>Head of Commissioning (GH)</p> <p>Personal Budget Support Officers (AH & GA)</p>
12. Take action to support Government’s target to eradicate fuel poverty as far as reasonably practicable, by 2016.	<ol style="list-style-type: none"> 1. Report on energy conservation measures that the Council considers practicable, cost-effective and likely to result in significant improvement in the energy efficiency of residential accommodation in its area. 2. Develop fuel poverty actions and targets as part of the ‘Climate Local Commitment’. 	<p>June 2013</p> <p>October 2013</p>	Climate Change Officer (JM)

Strategic Priority 3: Ensuring that older people have a positive experience of care and support	2013 - 2014 Objectives	Due Date	Responsible
1. Engage older people in all parts of the Borough with a planned programme of activities and consultation.	<ol style="list-style-type: none"> 1. Take relevant policy and procedure changes and service development plans through the Older People’s Board 2. Deliver the Aging Well event taking into account feedback from previous years 3. Introduce ‘Are we getting it right?’ Service User Questionnaire. 4. Run ad-hoc focus groups 	<p>Continuous</p> <p>June 2013</p> <p>October 2013</p> <p>Continuous</p>	<p>AD Community Care Services (JB)</p> <p>PA to AD Community Care Services (CM)</p> <p>AD Community Care Support (JB)</p> <p>Personal Budget Support Officer (AH)</p>

<p>2. Enable older people and carers to have choice and control over their care and support and the resources that pay for it.</p>	<ol style="list-style-type: none"> 1. Ensure that each person eligible for services knows how much their personal budget is and what flexibility they have to spend it on. 2. Introduce payment cards for direct payments 	<p>Continuous</p> <p>October 2013</p>	<p>AD Community Care Services (JB)</p> <p>Personal Budget Support Officer (GA)</p>
<p>3. Improve the range and quality of information, advice and advocacy services available to older people and, in particular, to people who are 'hard to reach'.</p>	<ol style="list-style-type: none"> 1. Evaluate Drop-in for Deaf People 2. Ensure advocacy information is available to people in hospital and care homes 3. Review Information Advice and Advocacy Strategy 4. Update the above and provide a new action plan 	<p>April 2013</p> <p>June 2013</p> <p>October 2013</p> <p>December 2013</p>	<p>Personal Budget Support Officer (AH)</p>
<p>4. Ensure everyone with end of life care needs is identified and their needs assessed.</p>	<ol style="list-style-type: none"> 1. Review Care home contracts to require care homes to support people to stay there to die if that is their wish 2. Review contracts with domiciliary care providers that require them to train staff that are competent to deliver palliative care and end of life care 3. Review contracts with care and support providers who deliver on site care in extracare settings to provide palliative care and end of life care, including breaks for carers by providing care workers who can step in for a few hours while the carer takes a break. 4. Ensure appropriate support after someone has been diagnosed with a life limiting condition for end of life planning. 5. Support for former carers after a bereavement, to come to terms with 	<p>June 2013</p> <p>June 2013</p> <p>October 2013</p> <p>October 2013</p> <p>June 2013</p>	<p>Commissioning Officer</p>

	their loss and to help them move forward in their lives.		
5. Ensure that unpaid carers are identified when the person with care needs is assessed, and ensure that the unpaid carers are referred to appropriate help, such as Carers in Bedfordshire and the Council's Adult Services.	<ol style="list-style-type: none"> 1. Increase the number of carers who are offered assessment and receive an appropriate service as a result 2. Monitor effectiveness of Carers Support Services (Carer's in Bedfordshire) 3. Increase number of Carers with an emergency plan 	<p>Quarterly report</p> <p>April 2014</p> <p>April 2014</p>	<p>AD Community Care Services (JB)</p> <p>Head of Commissioning (GH)</p>
6. Ensure sufficient capacity and quality of home care providers including providers who can meet end of life needs.	<ol style="list-style-type: none"> 1. Maintain approved providers agreements 2. Ensure website is kept up to date with changes 3. React quickly to quality concerns if they arise 	<p>April 2014</p> <p>April 2014</p> <p>Continuous</p>	<p>Contracts Officer (RC)</p> <p>Personal Budget Support Officer (GA)</p> <p>Head of Care Standards & Review (GB)</p>
7. Ensure that staff delivering care in all settings (home, extracare and in care homes) are competent to deliver care to people at the end of their lives.	<ol style="list-style-type: none"> 1. Identify the competencies required 2. Provide appropriate education and experience 3. Assess competence 	<p>April 2013</p> <p>April 2014</p> <p>June 2014</p>	<p>Commissioning Officer</p>
8. Improve quality of care in local care homes by implementing the 'My Home Life' programme.	<ol style="list-style-type: none"> 1. Hold a managers event to celebrate and share learning the My Home Life way across the Borough 2. Hold a wider stakeholder event to identify ways to work together better across agency and professional boundaries 	<p>June 2013</p> <p>October 2013</p>	<p>Head of Care Standards & Review (GB)</p>

Strategic Priority 4: Safeguarding older people whose circumstances make them vulnerable and protecting them from avoidable harm.	2013 - 2014 Objectives	Due date	Responsible
1. Protect people from discrimination or harassment due to their age, ethnicity, gender, physical disability, learning	<ol style="list-style-type: none"> 1. Implement the Safeguarding Strategy 2. Raise awareness of the need to 	<p>Continuous</p> <p>June 2013</p>	<p>AD Community Care Services (JB)</p> <p>Personal Budget</p>

disability, mental ill-health, sexuality or any other cause.	<p>safeguard vulnerable people.</p> <p>3. Raise awareness of Hate Crime and what to do if it happens</p> <p>4. Ensure Equality Analysis is undertaken as required</p>	<p>October 2013</p> <p>Continuous</p>	<p>Support Officer (AH)</p> <p>AD Community Care Services (JB)</p>
2. Enable increased use of home safety services.	<p>1. Raise awareness of the Bobby Van and increase utilisation</p> <p>2. Promote Neighbourhood Watch to increase public involvement</p> <p>3. Promote to older people the Council's 'Trusted Traders' scheme which accredits services such as housework, shopping, locksmiths and plumbers.</p>	<p>April 2013</p> <p>April 2014</p> <p>April 2014</p>	<p>Personal Budget Support Officer (AH)</p>
3. Implement and keep under review the joint strategy for the Safeguarding of Vulnerable Adults with partners.	<p>1. Complete strategy action plan</p> <p>2. Co-ordinate safeguarding activities with partners</p> <p>3. Audit safeguarding practice and evidence continued improvement</p>	<p>Continuous</p> <p>Continuous</p> <p>April 2014</p>	<p>AD Community Care Services (JB)</p>
4. Improve advocacy for people in care homes and extracare settings.	<p>1. Ensure information about how to access advocacy is available to residents and tenants</p> <p>2. Review specific advocacy activity in care homes and extracare and make recommendations</p> <p>3. Implement recommendations</p>	<p>June 2013</p> <p>October 2013</p> <p>April 2014</p>	<p>Personal Budget Support Officer (AH)</p> <p>Commissioning Officer</p>
5. Ensure specialist support is available out of hours for service users and carers living in the community.	<p>1. Review arrangements for Mental Capacity Assessment including out of hours.</p> <p>2. Review arrangements for Independent Mental Health Advocacy including out of hours</p> <p>3. Make and implement recommendations</p>	<p>June 2013</p> <p>June 2013</p> <p>April 2014</p>	<p>Commissioning Officer</p>
6. Do 'Meeting the Dignity Challenge' across Adult and Community Services	<p>1. Prepare materials and briefing for teams</p>	<p>April 2013</p>	<p>Personal Budget Support Officer (AH)</p>

	<ol style="list-style-type: none"> 2. Roll out programme across directorate 3. Support delivery throughout the year 4. Compile final report 	<p>April 2013 December 2013 April 2014</p>	<p>AD Business Support & Operational Housing (SW) Personal Budget Support Officer (AH)</p>
<p>7. Put in place the new PLACE assessments to replace the current Patient Environment Action Team (PEAT) inspections, in hospitals offering NHS-funded care, hospices and Independent Treatment Centres from April 2013.</p>	<ol style="list-style-type: none"> 1. Review national requirements and develop local plan for implementation 2. Ensure Healthwatch Bedford Borough has good communication channel with Bedford Hospital and SEPT re PEAT 	<p>April 2013 October 2013</p>	<p>Head of Commissioning (GH)</p>

Glossary

Advocacy	Support for people in making their own decisions and ensuring that their views are properly represented
Bedfordshire Clinical Commissioning Group (BCCG)	Bedfordshire Clinical Commissioning Group (BCCG) is a new organisation, run and led by local clinicians, including GPs, nurses and hospital doctors. We have come together to take over responsibility for planning, organising and purchasing NHS funded healthcare for the people of Bedfordshire. This includes hospital services, community health services (such as district nursing, health visiting and various therapies) and mental health services.
Commissioning	Planning, buying and reviewing of health and social care services
Direct payments	Money paid to you by your local Council so that you can buy your own care and support.
Fuel poverty	This is a where a household cannot afford to keep adequately warm at a reasonable cost. A fuel poor household is one that needs to spend more than 10% of its income on fuel use in order to heat the home to an adequate standard of warmth.
Health Inequalities	Refer to gaps in the quality of health and health care across, racial, ethnic, sexual orientation and socio-economic groups. Despite improvements, the gap in health outcomes between those at the top and bottom ends of the social scale remains large and in some areas continues to widen. These inequalities mean poorer health, reduced quality of life and early death for many people.
Joint Strategic Needs Assessment (JSNA)	NHS Bedfordshire and Bedford Borough Council working together to understand the future health, care and well-being needs of the community
Mental Capacity Act	Provides important safeguards to protect families, carers, health and

	social care staff, and other people who act and make decisions on behalf of people who lack the mental capacity to make the decision for themselves
Person centred planning	Putting you at the centre of planning for your life. Family, friends, professionals and services listening to and learning about what you want from your life and working together with you to make this happen.
Personal budget	This is the money you get from Bedford Borough Council, Adult Services.
Personal health budget	A personal health budget makes it clear to someone getting support from the NHS and the people who support them how much money is available for their care and lets them agree the best way to spend it.
Personal health plan	Designed to look at your health needs, make plans for better health, and tell people who need to know about your health.
Stakeholder	Any individual or organisation with an interest in health and social care services.
Strategy	Describes the services we have now and how we will develop these services over the coming years.