BEDFORD BOROUGH COUNCIL




Adult Social Care Services

The Local Account

2017/18

Contents

1. Foreword

Welcome to Bedford Borough Council's (BBC's) Local Account of Adults' Social Care 2017/18 and our Priorities and plans for 2018/19.

We are pleased to share our achievements over the past 12 months, building on our previous reports. This account demonstrates our commitment to be open and transparent with local people about what we do as well as some of the challenges we face.

We produce a Local Account every year and we continue to do all we can to empower local communities to enable them to shape the design and delivery of future services, through collaboration with service users, carers and multi-agency professionals.

We have an excellent record of delivering services through innovative practice and value for money. In recent years we have transformed our services with increased focus on delivering individual resilience, promoting independence, maintaining wellbeing, choice and inclusion, but we have further to go as we continue to face rising demands and increasing austerity measures.

We recognise the pivotal role of the Community and Voluntary Sectors in helping us to work together to support our most vulnerable people in the local community. It is our intention to continue to engage and to build on the strengths based approach to early intervention wherever possible to support people to maintain their independence and to support them to reduce the likely need for intrusive and dependent care models.

Your views are important to us. If you would like to comment on anything in this Local Account please contact Mark Harris, mark.harris@bedford.gov.uk

Councillor Anthony Forth
Portfolio Holder, Adult Services

Kate Walker
Director of Adults' Services

2. Reflections from Healthwatch Bedford Borough

Adult Social Care Services - The Local Account 2017/18

Healthwatch Bedford Borough (HBB) is pleased to be requested to comment on this important document.

The following comments refer to the relevant page number in the document as presented.

Page 8 – The references to dementia services within the Borough are welcome. The Bedford Borough Joint Strategic Needs Assessment (JSNA) highlights the need for the promotion of "dementia friendly communities" and particularly for support within Black and Minority Ethnic communities to avoid stigmatisation. Many of the services identified within this Local Account will be of considerable support both in the identification and support to those people affected.

Pages 10-12 – HBB is pleased to see the use of "I" style stories in demonstrating the outcomes to the work of the Local Community Co-ordinators.

Page 13 – HBB is a member of the multi-agency steering group working on the development of the Bedford Borough Social Prescribing model. There is no doubt that with effective management, this initiative will add greatly to improving the health and wellbeing of the local population.

Page 33 – HBB is pleased to support and participate in the work of the Mental Health Partnership Board. There is a considerable inter-relationship with other Partnership Boards/health and social care services. Again HBB would stress the need to include BME representatives/communities in this important work.

Page 41 – Deprivation of Liberty Safeguards – it is pleasing to note that Bedford Borough Council does not have a backlog of DoLS cases and is to be commended.

Page 50 – Safeguarding Training – HBB staff have recently been able to attend the Safeguarding training provided by the Borough Council – without exception all attendees made mention of the high quality of the training that was delivered.

Page 53 – HBB welcomes the Priorities as noted for 2018/19 – it hopes that there is an inbuilt recognition that in acknowledging "our shared local population" there will be a need to build approaches which will encompass the vulnerable communities.

29th May 2018

3. Introduction

This Local Account explains how Bedford Borough Council's Adult Social Care Services performed from April 2017 to March 2018. Improved outcomes are shown in the form of key performance information, illustrative examples and feedback from Service users, Carers, and partner Organisations.

Adult Social Care Services continues to face many challenges such as continual budgetary reductions, increasing demands and pressures deriving from an ageing local population who are living longer, which is good, but with increasingly complex needs. We are also seeing an increase in the needs of younger adults, as well as experiencing some difficulties with attracting and retaining a social care workforce. This is not unique to Bedford but demonstrates the need for innovative and creative thinking to sustain services due to potential risk associated with a fragile care market.

Overall the Local Account shows that Bedford Borough Council continues to deliver good services within available resources.

The Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework is published by the Department of Health and specifies outcomes in four areas.

- 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.

The areas have been used as the section headings in our local account. We hope that you find our account an interesting and honest critique of our progress.

4. What were the priorities for 2017/18?

- Integration with health services
- Review of service delivery model
- Further develop the 'early help' network to support independent living and supportive communities.

Integration with Health Services:

Better Care Fund

We have continued to make significant progress with our health partners building on areas of work that will make the biggest difference to our local population. We have reviewed where we are and have aligned our priorities through the development of our Integration and Better Care Fund Plan 2017-19.

This plan is a key mechanism for health and social integration in Bedford Borough. Our vision and outcomes with the Better Care Fund reflect the need to improve health and wellbeing for people of all ages in order to prevent, reduce and delay the number of people requiring health and care services both now and in the future.

Our Integration and Better Care Fund Plan for 2017-19 is the third plan developed in partnership between Bedford Borough Council (BBC) and Bedfordshire Clinical Commissioning Group (BCCG).

Last year, the Council and Bedfordshire Clinical Commissioning Group implemented the 2016/17 Better Care Plan supporting the joint vision for health and social care set out by the Health and Wellbeing Board. Our vision and ambition for transforming health and social

care in Bedford Borough is:

"All adults are able to live healthy, safe lives, and are provided with the opportunities to realise their full potential; and all adults have the support they require to lead healthy and independent lives and receive timely access to high quality, appropriate health and social care."

In the past year, as in previous years there are notable improvements that have created stronger foundations upon which to build in subsequent years, thereby ensuring continued progress towards our vision and ambition.

Pages 45-50 illustrate some of our key achievements which we are proud of, showing how our journey is going, and how the progress in the last year is making a real difference to the wellbeing of our local population and the outcomes achieved.

Community Health Services

In 2017/18 we worked with our health partners on the re-procurement of Community Health Services. The contract, awarded to East London Foundation Trust (ELFT), provides a range of adult and children's community health and care services and other specialist services including nutrition and dietetics, podiatry services, wheelchair services, community dental services, as well as drug and alcohol services for children and young people. This contract enables us to continue delivering high quality health and social care services to local people, that will be safe, fit for purpose and sustainable. ELFT have also provided Mental Health Services to Bedford Borough for a number of years, and we envisage using the positive networks we have developed with them, over this time, to affect positive change rapidly, in their new role as the community health services provider. Details of progress made can be found on page 45.

The Out of Hospital Strategy:

In 2017 with new emphasis on integrated approaches we began a journey in partnership with Bedfordshire Clinical Commissioning Group (BCCG) on the development of an Out of Hospital Strategy which draws together a number of key areas of work, some of which has already been or is being delivered.

The aim of the strategy is to ensure that the health and care system in Bedford Borough helps to support local people to remain as healthy and independent as possible for as long as possible; and when they need support they receive joined up and co-ordinated care in a timely manner as close to home as possible.

A few of the areas already under way are:

- Fusion Stroke Rehabilitation is a community-based training programme that promotes functional independence and physical fitness in stroke survivors after formal rehabilitation. It is delivered by our partners Fusion Leisure Services who are part of the stroke pathway and are involved in the Early supported Discharge services to assist people to maximise their independence following a stroke.

- Stroke Association – The service has been redesigned by BBC Commissioning, following the success of a pilot project. Six month reviews have been incorporated into the service, with the Stroke Association responsible for completing 60% of these. The new service is working closely with Early Supported Discharge Services who complete the remaining 40% of six month reviews.
- Dementia Services – a review of specialist dementia in local people requiring 24 hour care. The service provides training to care homes to upskill staff but will also respond to patient crisis, both in the community and in care homes.
- Jointly commissioned third sector dementia services – Tibbs Dementia Service and Carers in Bedfordshire's Dementia Navigation Service, supporting people who have memory problems or who are diagnosed with dementia. The service works closely with the local memory clinic to support diagnosis.
- Joint Dementia Strategy 2016-2019 – Updated May 2017
- NHS England's Dementia Target - Joint commissioning via third sector providers to support NHS England requirement to meet our dementia diagnosis target.
- Jointly commissioned services with BCCG – Carers services, Community Equipment Service.

All of these projects have already seen strong outcomes for those people we are supporting, and we are already planning new innovative ways to build on this work.

Review of service delivery model

We continued to make progress with a review of our adult service delivery model and paused the concept of embarking on a specific provider arm. Adult Services will instead be part of a service redesign commencing in 2018/2019. The redesign of Adult Services will consider our future delivery as part of a Transformation Programme which will enable us to communicate more effectively, such as on line, and will be designed to be more accessible to you, our residents.

Through our work on the Better Care Fund, the Out of Hospital Strategy and work on the procurement of Community Health Services we are also considering a more joined up approach to ensure Adult Social Care link with our partners going forward.

Further develop the 'early help' network to support independent living and supportive Communities

Bedfordshire Rural Communities Charity was awarded a contract, following a tender process, to develop Local Community Coordination in Bedford Borough from April 2017.

The target group for the Local Community Coordinators (LCCs) to work with are people with some vulnerability but who are not yet eligible for Council social care services.

The LCCs work with people to achieve the following outcomes to prevent, reduce or delay the onset of eligibility for Council social care services:

- Increase informal support relationships – reducing isolation
- Increase capacity of families to continue in caring role
- Improve access to information
- Better resourced communities
- Improve access to specialist services
- Support into volunteering, training and employment
- Preventing crises through early intervention
- Changing the balance of care to the use of more informal community support

Following the award of the contract 2 full time and 2 part time Local Community Co-ordinators were recruited and have been working in Queens Park; Kingsbrook and Cauldwell; Goldington and Putnoe since July 2017 and in Kempston since August 2017.

The Coordinators have established themselves within their areas and built links with voluntary organisations and statutory services, local GP Practices and community/neighbourhood groups. During the first year referrals have mainly been through self-referral, GP and from other organisations.

The Coordinators have received training in and started to use the Outcome Star model. This is an evidence-based tool for measuring and supporting change when working with people. This method puts importance on the individual's priorities and perspective as in a person centred approach.

During 2017/18 the Local Community Coordinators worked with 183 clients. 105 of these were complex cases requiring multiple contact, and 75 were simpler, single issue contacts (for 3 this has not yet been recorded).

Client Case Studies

Client A

Situation

- 96-year-old lady who until very recently was going out and about on a daily basis, attending exercise groups and the WI.
- Just before Christmas she was diagnosed with macular degeneration which really affected her confidence. She stopped going to her exercise group and refused to go out.
- Her son referred her as he wanted her to go out and meet more people and get back to enjoying life.

Action taken

- Discussed with the client what she wanted to do.
- Trained her in safe 'sit to stand' procedure
- Introduced her to the Guild House activities
- Applied for a Blue Badge (awaiting decision)

Outcomes to date

- Client has increased self confidence
- Client now feels confident to go on the bus and get involved in new activities at the Guild House
- Client is now safer at home and less likely to fall when getting up from her chair

Client B

Situation

- Widow aged 66, lives by herself in her own home, referred by GP for transport options
- Asian and speaks very little English
- Suffers with bilateral knee osteoarthritis which limits her mobility.
- Was working part-time despite reaching retirement age as on a low income and struggling to make ends meet. Had to give up her part time work due to her condition.

Action taken

- Completed a blue badge application to allow her drive to the local shops
- Noticed there were no disability aids in her home so contacted One Call and arranged for Occupational Therapy (OT) to provide aids, and discussed the possibility of having a downstairs shower room/ stair lift as Mrs. K's bed is downstairs as she cannot walk upstairs.
- Completed grant application form for wet room, which will help her independence as she will not have to rely on her daughters-in-law to shower/bathe her.
- Carried out a benefits check - did not qualify for pension credit but qualified for a reduction in her council tax.
- Contacted DWP to claim attendance allowance due to her disability and completed form for her

- Contacted energy supplier for winter warmth payment and to be placed on priority register
- Has multiple medical conditions therefore requested a medicine box for all her medication
- Referral made to community physio, as concerned the little mobility she has in her knee will cease if she does not exercise regularly

Outcomes to date

- Now has a blue badge and finds it much easier to travel to the local shops
- Enabled to continue to live independently in her own home through installation of mobility aids (2 commodes, handle on bed, step on front door, hand rails in kitchen and bathroom).
- Receiving medication in a medicine box making it much simpler for her to take her medication.
- Council tax has been reduced as living on her own which helps with her low income.
- Winter warm payment has helped reduced fuel bill

Client C

Situation

- Client is 64 and has long term health conditions and decreasing mobility
- Lives with his mother who is 80+ years old, he acts as her full time informal carer as her mobility is compromised and she has decreased ability to complete daily tasks and care for herself.
- Wanted to know what support is available for carers. Following on from this, a discussion was had to what would help with his caring role. The client also wished to improve his own health which has progressively been deteriorating.
- Referral Method – Self referral

Action taken

- Completed a carers grant (Carers in Bedfordshire) with the client.
- Supported client with the purchase of a sofa-bed to enable his daughter to stay over to provide him with some respite (short break).
- Supported client to engage with lifestyle hub to improve clients' health and wellbeing enabling him to continue his role as a Carer in the future.

Outcomes to date

- Client received the carers grant and purchased the sofa-bed

enabling his daughter to stay over and support with the care of his mother when the client needs a break.

- Client was referred to lifestyle hub and has since started to go swimming twice per week to improve his own health.
- With the support of the LCC the client has been able to continue caring for his mother, which is very important to him, and look after his own wellbeing.
- This has hopefully prevented the need for external carers to provide homecare for his mother.

Bedford Borough Social Prescribing Service

In November 2017, the Bedfordshire, Luton and Milton Keynes Sustainability and Transformation Partnership (STP) proposed that social prescribing models should be developed and implemented across the whole area. A multi-agency steering group led by Bedford Borough Council was established to develop the Bedford Borough Service which will be piloted in Kingsbrook, Cauldwell, Queens Park, Goldington and Kempston Wards.

The intention is to roll the service out across Bedford Borough

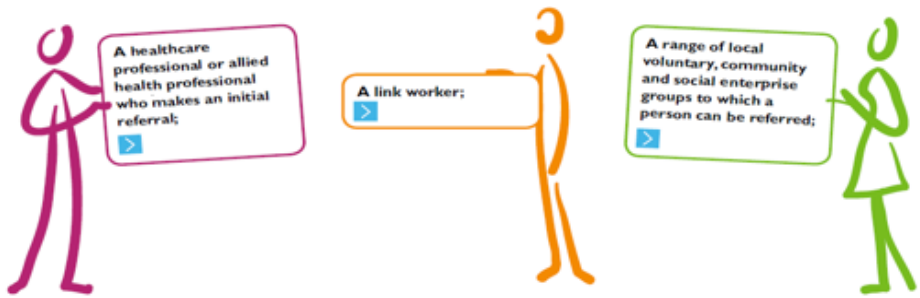
Social Prescribing enables health and social care professionals to refer patients with social, emotional or practical needs to a community link worker who can support them to find non-clinical solutions that will improve their health and wellbeing.

An estimated 20% of patients consult their GP for what is primarily a social problem however the 'tools' available to a GP may only have a limited impact. The additional knowledge and support available in our communities can offer personalised and flexible support to help people progress and self-manage their situation.

Adults aged 18 and over who are identified as having mild to moderate anxiety and depression and/or feel socially isolated, are offered a referral by their primary care practitioner to a Local Community Coordinator. The subsequent action plan, which is co-produced with the individual, may include a number of interventions or activities that will help address issues such as finance, education, housing, self-esteem and isolation. The Coordinator will maintain regular contact with the individual over a non-specified period of time, although it is expected that most people will exit the service within 6-months.

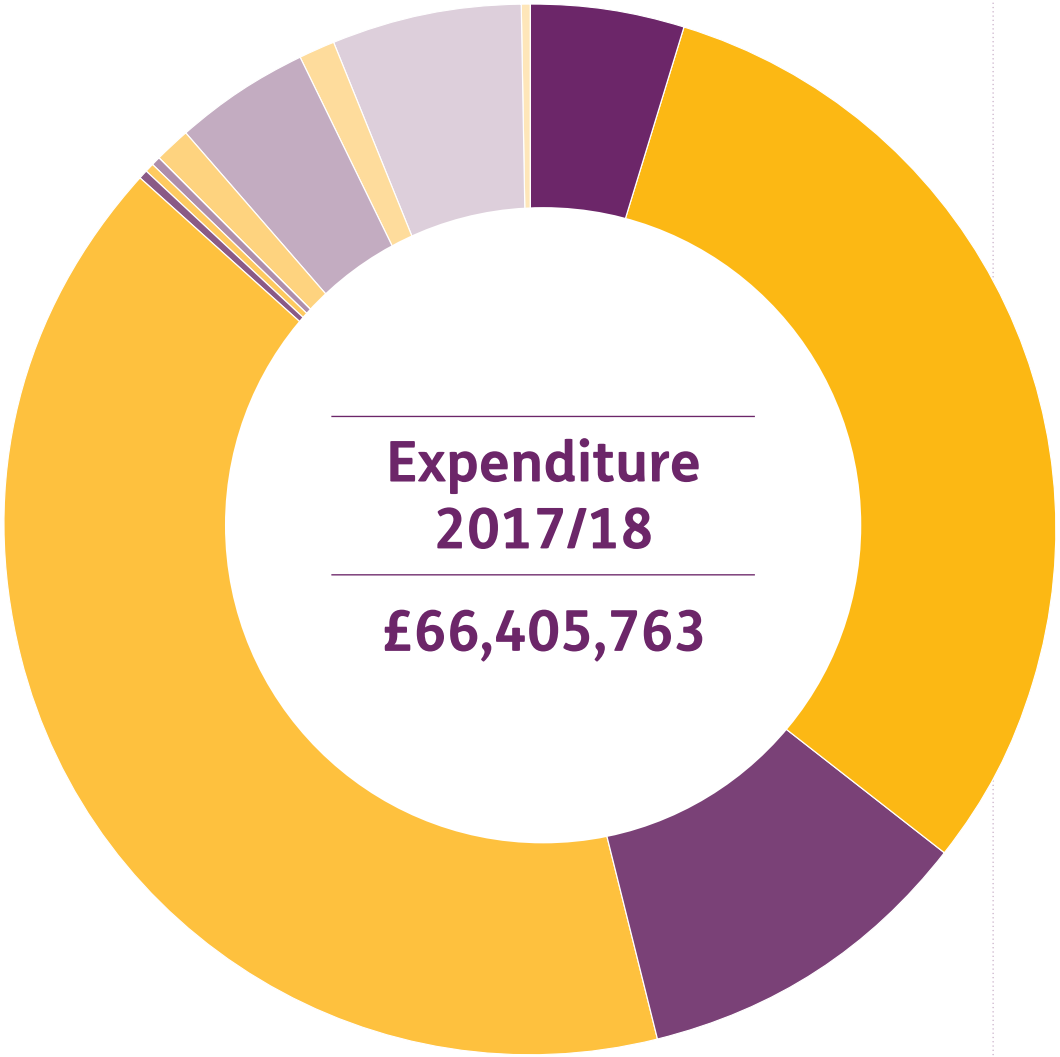
The Local Community Coordinators i.e. link workers, are employed by Bedfordshire Rural Communities Charity (BRCC) and Bedfordshire Community Voluntary Services (CVS) is supporting a wide range of voluntary sector organisations to be part of the service. All voluntary sector organisations must have a minimum level of quality assurance prior to them being accepted as a referral source.

The Social Prescribing Team Leader was appointed at the end of May 2018 and the pilot will begin in earnest at the end of June 2018.



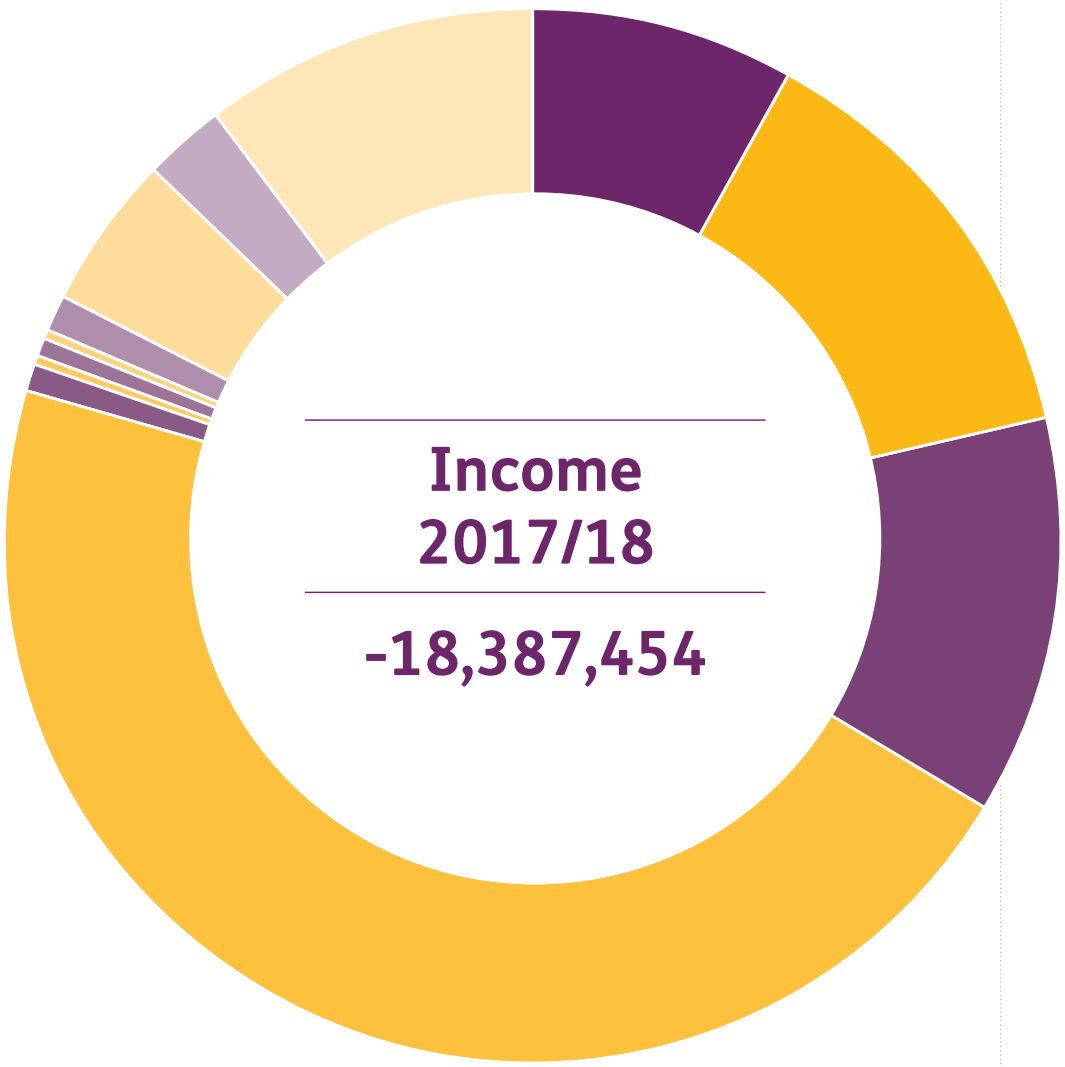
5. How much did we spend?

Income and Expenditure - 2017/2018 Adults' Services



Expenditure

Memory & Cognition	3,160,592
Learning Disabilities	20,406,402
Mental Health	6,931,617
Physical Support	26,739,958
Sensory Support	282,879
Social Support - Socialisation	480,829
Social Support - Support for Carer	268,477
Social Support - Substance Misuse	34,197
Assistive Equipment & Technology	604,444
Social Care Activities	2,857,805
Information & Early Intervention	710,432
Commissioning & Service Delivery	3,884,521
Adult Community Learning	43,611
Total Expenditure	**66,405,763**



Income

Memory & Cognition	-1,484,189
Learning Disabilities	-2,459,240
Mental Health	-2,247,009
Physical Support	-8,466,537
Sensory Support	-119,603
Social Support - Socialisation	-66,690
Social Support - Support for Carer	-92,426
Social Support - Substance Misuse	-34,197
Assistive Equipment & Technology	-233,635
Social Care Activities	-863,332
Information & Early Intervention	-445,828
Commissioning & Service Delivery	-1,874,768
Total Income	**-18,387,454**

6. Enhancing quality of life for people with care and support needs

Personalisation

Personalisation is described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings".

In Bedford Borough we have expanded on this description and developed an ethos that means Personalisation goes far beyond direct payments and personal budgets, and means service users are central to tailoring their own services to fit their needs and to move away from standard inflexible models of provision.

By developing teams across services we've been able to start this process from the inception of service development, with input from service users via our commissioning and procurement services, through to the review and feedback on services by building on the success of our partnership boards and Care Standards team.

We have also improved the provision of information and advice on care and support for families, carers and service users, through close work with partnership agencies such as Carers in Bedfordshire, whilst also developing innovative schemes such as digital (on-line) resources for carers via www.carersdigital.org (Free access code DGTL9072).

The Care Act has further reinforced this work and also informed work around making Safeguarding Personal. As an organisation we have worked with partnership agencies to ensure that safeguarding is a process that works with people, rather than a process that is done to them, to ensure that we are clear about their desired outcomes at the start and throughout the process. Training has been provided to teams and the approach is already seeing measurable benefits for people and offers us an opportunity to review outcomes and review support to ensure we strive towards continued development.

As part of personalisation people with a physical or learning disability were enabled to take part in sport and physical activity of their choice.

People with personal budgets

Every person eligible for support from the Council's Adults' Services is offered a personal budget so they can control how their needs are met. This year the number of people receiving self-directed support was 2800. Work continues to encourage the use of personal budgets rather than traditional formal service offers.

Take up of personal budgets from 2012/13 to 2016/17

People aged from 18-64 years	2013/14	2014/15	2015/16	2016/17	2017/18
Physical Disability 18-64	291	342	333	376	**363**
Mental Health 18-64	109	151	169	149	**131**
Vulnerable People 18-64	23	23	29	29	**19**
Learning Disability 18-64	324	349	354	348	**366**
People aged over 65 years	1151	1521	1547	1674	**1615**
Carers	337	366	404	351	**306**
Grand Total	2241	2753	2841	2927	**2800**

Carers' Breaks (respite)

Sometimes a carer needs a break from the caring role. It can be for a few hours or several days depending on individual circumstances. These breaks often support the carer to continue in their role and to sustain their relationship with the person they are caring for. As an organisation we never underestimate the vital role carers provide and the importance of them being able to sustain this input.

In 2017/18 13,456 days of respite care were provided where the person being cared for stayed away from home overnight. A breakdown for each care group is in the chart below.

The number of carers break days for each service user group 2017/18

Client Group	Number of days 2013/14	Number of days 2014/15	Number of days 2015/16	Number of days 2016/17	Number of days 2017/18
Learning Disabilities	2781	2932	3052	2874	2275
Mental Health	651	1132	2277	1030	1189
Older Persons	9859	11026	12880	10281	6702
Physical Disabilities	1424	1088	832	2593	3097
Substance Misuse	731	1121	525	574	193
Grand Total	**15446**	**17299**	**19566**	**17352**	**13456**

In 2017/18 we focused on improving the timeliness of reviews for people who found themselves in emergency respite placements, this has enabled supported decisions regarding longer term care needs of the individual and their carer to occur sooner, which has reduced the time needed in short term placements.

Appointee

Some people need help to claim benefits because they can't manage their own affairs. Another person called an appointee can be given the legal right to act for them. This process is supported by legislation, including the Mental Capacity Act, and enables us to

safeguard people's financial affairs in a structured way. The Council is appointee to 213 people.

Public Health

Public Health provide services, evidence and information on a broad range of health and wellbeing issues, to improve local health and wellbeing and reduce health inequalities. In 2017/18 this included:

- Implementing the Healthier Options Food Award to support businesses, leisure centres, workplace cafes and visitor centres to offer healthier menu options to their customers. Three organisations achieved the Award between January 2018 and the end of March 2018.
- Continuing to commission BeeZee Bodies to deliver a range of weight management programmes for pregnant women, children, young people, families and adults.
- Commissioning General Practitioners (GPs) to deliver free NHS Health Checks to adults aged 40 to 74.
- Commissioning Cambridgeshire Community Services to deliver sexual health services for adults and young people across Bedfordshire. The new Kings Brook Clinic opened in April 2017.
- Launching the online sexually transmitted infection(STI) postal express test kits in November 2017.
- Supporting over 500 residents to stop smoking and delivering specialist treatment programmes to vulnerable groups.
- Developing a Bedford Borough Social Prescribing Model.
- Commissioning East London Foundation Trust (ELFT) 'Path to Recovery' (P2R) to provide drug and alcohol treatment.
- Providing support, advice and guidance to families, children and young people through the 0-5 Health Visiting and 5-19 School Nursing teams.
- Refreshing the Joint Strategic Needs Assessment (JSNA), which is a local assessment of current and future health and social care needs; available on the Council website.
- 101 flu vaccinations delivered to Bedford Borough Staff
- Flu awareness talks delivered to the Bedfordshire Carers Forum and in sheltered and residential settings in Bedfordshire. Public engagement events at Carers forum, lunch clubs, Kempston town hall, Ampthill Road and Queen's Park Gudwara health event, Queen's Park community health event
- Infection Prevention and Control Training- 07/04/2017- 28 Health & Social Care Workers

Shared Lives Bedford Borough

Shared Lives Bedford is a registered scheme with the Care Quality Commission, run by Bedford Borough Council, which links people who need help and support to live in the community, with people who can provide that help and support in their own home. It supports people with a learning disability from age 16 years into adulthood. Support

can vary from short breaks, community access during the day time or on a full time basis. The ethos is that a shared lives carer opens up their home and family life to include a young person or adult who needs extra support to live well. It's a way for people to share family and community life. It can often result in people with support needs doing things for the first time in their lives such as joining a local club or community group, making friends or going on holiday. People can also be involved in activities such as going to the theatre, cinema, visiting the pub or going for a walk and a chat.

The scheme aims to support and oversee the provision of placements for people within a safe and homely environment, based on ordinary living principles and to support each individual to live a fulfilling life.

The Bedford scheme currently supports 8 long term placements, 1 community access placement and 1 placement transitioning from short breaks to a long term placement. During 2017/2018 our Shared lives has responded proactively to the needs of more people who could access the service, and plans to be more central to the work of the Adult Learning Disabilities Team in the forthcoming year, with the aim of promoting and recruiting more carers.

Shared Lives follows nationally recognised rigorous training, approval and matching processes, recruiting and training carers to make sure becoming a shared lives carer is the best match for the individual, the carer and others. During the approval process carers are screened, undertake training in the roles and responsibilities of caring and they develop important oversight of key legislation to help them to be the best carers possible with the right skills.

Matching is a key part of the journey to ensure compatibility through sharing some interests and ambitions. After successful matching, transition visits and overnight stays are progressed and if everyone is in agreement, the placement agreement is signed and the placement will formally begin.

Shared Lives Bedford oversees the placement providing support and information to both the individual and the carer through regular visits.

All of the individuals supported through the scheme and carers have a close bond, the support is very individual and person centred.

For further Information email shared.lives@bedford.gov.uk

Shared Lives – Case Study A

I have been living with my Shared Lives Carers for the last 2 years, before that I lived with my Mum but the time was right for me to move out.

I am really happy and I have changed a lot since I went to live with my carers.

I used to be a very quiet nervous person. I did not go out on my own. I was not very independent and I was not very good at taking care of

myself. I couldn't manage my own money.

How my life has changed!

Now I have a great life and I have lots of hobbies and interests that I get support with. I am really interested in steam trains and when I was on holiday with my Shared Lives Carers we went on the Somerset Steam Railway. I also love history and have been to Buckingham Palace.

We have been on some really good holidays such as Center Parcs, Butlins and on a Mediterranean cruise.

I use the bus on my own now and I like to help out, so I have taken on the job of buying the bread and milk we need. I feel good that I can do this.

I have a volunteer placement at Bedford Library. One of my jobs is preparing new books to go out on the library shelves.

Shared Lives has given me the chance to live my life as I choose - with the right amount of support for me. I feel part of the family and that is very important to me.

Independent Travel Training

In 2017/2018 Adult Learning Disability Day Services worked with people to promote their levels of independence and safety. A key area of focus has been on travelling. Travel training is where an individual is trained to travel a route from one specific point to another. This is so the individual can familiarise themselves with the specific route and the safest places to cross using road safety skills. Such training can include using public transport, such as buses and trains or travelling on foot.

The Team provide a training assessment which will usually take around 8 sessions per person, but the training plan can vary if the individual requires additional support and guidance. Thanks to this work in 2017, 28 attendees now travel independently.

Travel training supports an individual to develop a range of skills that will enable them to travel independently. Skills include using money to pay a fare, recognising land marks as point of reference, using a mobile phone, journey planning using a timetable, responding to unexpected situations, personal safety and finding places of safety in the community.

A member of the team works with the individual on a one to one basis throughout, and begins by introducing them to the route and slowly over time begin to step back as the person develops. In the final session the staff member will follow the individual whilst they complete the route independently. This then allows them to step in

should they need to or if the person is at risk. They will only complete this part and sign it off if they have demonstrated throughout the process that they have reached a level of competency and safety.

Independent travelling makes a real difference to people's lives, which can be seen in how the people have gone on to achieve positive outcomes; such as people moving into supported living accommodation, or obtaining employment and social networks that they can get to without support. The team reflect on these great achievements and are keen to offer the travel training to more people in the future as well as to continue to develop other areas of independence and daily living skills.

Local Artwork at the Higgins - Mosaic - Bedford Through Our Eyes

Service users at the Centre for Independent Living have created a mosaic all about living in Bedford, which is now a permanent part of the art collection proudly on display at The Higgins Bedford.

The mosaic, called 'Bedford Through Our Eyes', is the result of a 12 month project with service users at the Centre exploring Bedford through creative art at The Higgins Bedford. The artists learnt about art materials and mosaic techniques, whilst talking and bringing to life some of their favourite parts of living in the town.

The idea stems from the concept of uncommon people. The artists are a group of uncommon people, they are ethnically, religiously and culturally diverse and all have some form identifiable difference due to disability. Service users wanted to celebrate and unite shared lifestyles within Bedford and truly represent how they feel embraced by the Bedford community and how they see it through their eyes.

They created a map of Bedford that incorporates ideas, images and views of the diverse elements that come together to make Bedford what it is and how they contribute to its flavor. They created the mosaic using a range of materials including recycled and unwanted objects to showcase how things that seem less than perfect on the surface can come together and create something beautiful that

can be appreciated by all. All the artists involved and their family and carers were invited to a private Celebration Tea Party, and to see their mosaic hanging as a permanent feature in the courtyard at The Higgins Bedford. Hopefully, raising awareness of how much we can all contribute and enrich our community and to celebrate the support and care we, as a group, receive from members of the Bedford community

7. Delaying and reducing the need for care and support

Helping adults and older people to live independently

The most usual way of doing this is by arranging a care worker to help the person with tasks like getting up and going to bed, keeping clean and tidy, eating and drinking properly and managing household bills. Whenever possible this support will be provided in a way that develops independence and is strengths based, this means that we' will work with an individual to build on their existing strengths rather than focus on things they have difficulty achieving. In 2017/18 we helped 3,616 adults with services like these.

Re-ablement

In 2017/18 485 referrals progressed to a reablement assessment, of these 288 were referred from the hospital. Many of these people would have been at risk of admission to residential care were it not for the reablement team. The Reablement Service received £105k additional funding in 2017/18 to expand the take up of reablement for all adults. Reablement is about helping people regain the ability to look after themselves following illness or injury. This is an important part of our prevention agenda, aiming to keep people as independent as possible, for as long as possible.

Reablement assists individuals to identify their aims and goals to be achieved in daily living by working with reablement staff to build levels of confidence. It utilises telecare to increase independence and minimize risks. The aim of the additional investment was to increase the number of individuals referred to reablement services and reduce the reliance on homecare services as the number of individuals becoming self-caring increased. In 2017/18 the rate of self-caring achieved at the end of March was 46%.

Number of people living in residential care who have been placed by the Council

The increase in the number of people admitted to residential care, in spite of all the services in place to prevent that, is evidence that the long term forecast 'demographic time bomb' is starting to make itself felt.

Number of people living in residential care who have been placed by the Council

Admissions	2013/14	2014/15	2015/16	2016/17	2017/18
Older People	445	407	454	465	562
Adults 18-64 years	134	144	152	161	180
Grand Total	**579**	**551**	**606**	**626**	**742**

Telecare

The Telecare service provides a range of personal alarms that can send alerts to relatives and/or neighbours when a person needs support. Other equipment available includes fall detectors, medication dispensers, excessive heat / smoke detectors and 'silent' panic alarms. In 2017/18 the service helped 1529 people within Bedford Borough.

Community Equipment

The Community Equipment Service is jointly commissioned between Health and Social Care across Bedfordshire and Luton. The service provides a range of equipment to promote safety and independence, facilitate hospital discharges and prevent admissions to care. The service provided equipment to 882 adults and 123 children in 2017/18.

Bedfordshire Care Directory

The Care Directory is a popular resource with over 2,000 copies distributed across the Borough.

It is available in print and e-book formats with new editions each May. It includes listings of care providers for care at home or residential care along with information on health and wellbeing, community involvement, staying independent and charging and funding. www.bedford.gov.uk/health_and_social_care/help_for_adults/residential_and_nursing_homes/bedfordshire_care_directory.aspx

Ageing Well Exhibition

For the third year we commissioned Age UK Bedfordshire to organise and run the Ageing Well Exhibition. Over 500 people attended the event at the Bedford Corn Exchange on 19 July 2017. 36 organisations and services provided information, advice and guidance on the wide range of services and opportunities available to older people in Bedford Borough.

Seven activity taster sessions were put on for people to join or watch including yoga, tai chi and a choir.

Feedback from Ageing Well Exhibition 2017

'Really good event with lots of organisations together.'

'Good variety of information – friendly atmosphere.'

'Good to learn about agencies and different information sources.'

Age UK already has advanced plans in place for this year's Ageing Well Exhibition which is due to take place on 27 June 2018 at Bedford Corn Exchange. This exhibition is held in the summer whilst the weather is warmer as requested by our local residents rather than in October, the traditional date to celebrate International Older People's Day.

Falls Prevention and Awareness

Falls continue to be a major cause of disability and the leading cause of mortality resulting from injury for older people. In 2017/18, emergency hospital admissions due to falls in Bedford Borough residents aged 65 years and over were higher than the England average. The number of hip fractures continues to decrease and is currently lower than the England average (www.fingertips.phe.org.uk) however it is important to remember that there is an ageing population and in excess of 95% of hip fractures are fall related.

The local Falls Prevention and Awareness Manuals developed for use in residential and nursing homes continue to be implemented by Care Home Falls Champions and in 2017 the manual was updated to include extra care housing. Free falls awareness training for existing and new Falls Champions continues to be offered to all care homes across the Borough.

The role of the Falls Champion is to:

- Lead the falls prevention work within their care home
- Act as the main point of contact for falls related matters
- Attend falls prevention meetings which are led by Bedfordshire Clinical Commissioning Group and Bedford Borough Council and provide education, training and peer support
- Monitor and report anonymised activity data
- Provide guidance updates to their wider care home team

The most effective method of falls prevention is community based strength and balance exercise programmes, particularly if they are tailored to the needs of the individual. Even those who take up exercise in later years reap significant benefits from participating in strength and balance exercises. Bedford Borough Council's Sports Development Team led a pilot project to develop care home staff into exercise leaders capable of delivering physical activity classes for their residents. The team is currently exploring ways to expand this work and they also provide a wide range of community based activities including those for the over 70s and gentle exercise classes: www.bedford.gov.uk/leisure_and_culture/sports_development.aspx

The Council's 1st Response Team continues to provide an assessment to people who have fallen within their own home and called an ambulance but do not require any medical assistance or admission to hospital. They provide equipment, advice and information and will liaise with relevant support services if required.

Disabled Facilities Grants (DFG)

Disabled Facilities Grants are used to fund adaptations to promote safety and independence within an individual's own home.

Bedford Borough Council spent £1,272,503 on Disabled Facilities Grants in 2017/18, resulting in 155 major adaptations being completed such as a level access showers, stairlifts or ground floor facilities to meet long term needs.

Minor adaptations were also completed to meet the needs of 475 people funded by Bedford Borough and BPHA. These included the installation of grab rails, stair rails and minor changes to allow clients to safely access their homes.

Lifestyle Hub

The Lifestyle Hub is a central point of contact for weight management and physical activity programmes.

A trained team of Lifestyle Advisors use motivational techniques to deliver a healthy lifestyle approach that is unique and new to the residents of Bedford Borough.

Individuals are referred in by Primary Care and reviewed on a one to one basis in an informal, relaxed atmosphere. Lifestyle Hub operates from 4 different venues including evenings and Saturday mornings to suit all schedules. All individuals have the opportunity to discuss their experiences, likes and dislikes in relation to diet, exercise, smoking and other lifestyle factors.

The Lifestyle Advisor will then suggest referral programmes and signposting options based on the information presented by the individual. The advisor can also explain the eligibility criteria and prices of these programmes. If the person doesn't choose one of these options or doesn't want try one, then together with the Lifestyle Hub Advisor they can agree on achievable and realistic targets to increase physical activity and make simple diet changes/ swaps under the Let's Get Moving Programme.

Everyone is offered the opportunity to review their goals and progress to ensure they are supported through the process with a further 3 follow up appointments over the next 24 weeks.

So far the Lifestyle Hub has accepted just over 5000 referrals.

71% of patients report their overall experience with the Lifestyle Hub to be "excellent" and a further 26% report their overall experience as "very good".

Mindful Sport

The Mindful Sport initiative led by the Borough Council Sports Development Team offers physical activity sessions that are specifically designed for people with mental health problems such as anxiety, post-traumatic stress disorder and depression.

The first session began back in June 2015 as a one off Yoga pilot session for 6 weeks and now has extended to 6 sessions spread across the week.

The programme launched a further new session for young people at World Mental Health Day in October 2017 and the attendances across the sessions have continued to grow whilst some participants have also moved on to other local sports clubs and activities.

The programme is managed by the Sports Development Team who has collaborated with the NHS Trust ELFT Wellbeing service, Community Adolescent Mental Health Services (CAMH) Bedford, Luton and Milton Keynes (BLMK) ELFT mental health service for

young people and Mind BLMK to promote the session to those in the community experiencing mental health problems. No diagnosis is required to attend any session and participants can attend via self-referral which is encouraged to build a dynamic and progressive group. Participants are signposted to local wellbeing services during the social drinks groups that follow each activity.

In the last 7 months since the World Mental Health day event that took place in Bedford there have been over 1000 attendances across the sessions from over 200 different people.

There have also been over 246 volunteer hours and through volunteers from the University of Bedfordshire and the Higgins gallery.

The adults only Mindful swimming session on a Wednesday evening launched in October 2017 has welcomed over 260 people to the gentle and calm pool session. The pool has gentle lighting and calming music, the unique environment offers an evening mid-week option to de-stress.

The programme now offers sessions throughout the week at central locations including The Higgins Museum, John Bunyan Sports and Fitness, Bedford Central Library and Robinson Pool. All session costs just £2 or £3 and are delivered on a first come first served basis.

The Sports Development Team is keen to continue to support the wider community with a range of activity sessions which focus on mental health and wellbeing.

8. Ensuring that people have a positive experience of care and support

Care Standards Monitoring and Review Service

The Care Standards Service has two work streams - Monitoring and Review.

The Monitoring Service

The Care Standards team continues to have two work streams for monitoring all registered care provision within Bedford Borough, a quality assurance database that enables quality assurance referrals to be submitted by internal care management and safeguarding teams either relating to a service user directly or a service provision.

The other tool for monitoring and assessing standards of care that has been introduced to the team over the last year to be in line with the Association of Directors of Adults' Services (ADASS) Eastern Region local authorities is the Provider Assessment Marketing Management System (PAMMS). This is a web based monitoring tool that is designed to support data gathering, workflow management and analytic information. PAMMS uses the same fundamental standards as the Care Quality Commission (CQC), Safe, Effective, Caring, Responsive and Well-led.

On completion of this assessment the provider gains a rating Excellent, Good, Requires Improvement or Poor, where actions are identified the team will support the provider to complete an action plan with clear outcomes.

Key Figures	2015/16	2016/17	2017/18
Quality Assurance (QA) (including Good Practice)	174	165	250
Routine Site Visits (excluding monitoring assessments or QA)	191	98	40
Monitoring Assessments	40	87	70
Provider of Concern Meetings or Serious Concerns	0	0	6
Temporary Suspensions	4	1	5
Provider Forums	4	0	1
Contract meetings (from May 2017)	N/A	N/A	26

The Care Standards ethos is to have a proactive approach to risk with support to providers at an early stage of difficulties being identified by coordinating input from partner agencies and services to minimise risk of harm to individuals and provider failure. We actively liaise with (CQC) inspectors sharing information and intelligence where we may have a provider concern that has led to the instigation of a provider action plan, both ourselves and the inspector see it as more productive that they may delay a visit or inspection until the action plan has been completed so that they can see that the changes made are being maintained by the provider.

Recent organisational changes within the Council have seen the Care Standards Team move to the Adult Services Directorate. This move has further strengthened existing relationships across the directorate and operational teams in particular information sharing and the extensive joint working with the Bedford Borough Safeguarding Team.

The Review Team

The Review Team carry out an annual review for all those people who have a package of care support in place, whether they have a Learning, Physical, or Sensory Disability or are over 65 years of age. The review meeting is an opportunity for a discussion to look at the current support package to check it meets assessed needs and achieves the required outcomes. The meeting is also an opportunity to evaluate the service provision and consider if changes are required to enhance the efficiency of the service and the person's experience. Reviews can take place in the persons own home, day centre, residential or nursing home. Over 2,000 reviews of this type took place in 2017/18.

An annual care review is provided for all service users who have a funded package of care support from the council; those who have been assessed as self-funding their own care are also offered this service.

Section 27 of the Care Act 2014, outlines the importance of the Annual Review of support services, as both a revision and reassessment of the support and care plans that are in place. The review process ensures that we liaise with the service user, keeping them at the centre of the review and obtain their feedback along with family, next of kin, carer and provider to obtain their overview on the support that is in place.

There is a clear focus on service user strengths, family, community networks and encouraging service users to be pro-active in achieving greater independence.

The review meeting ensures that services in place are supportive and effective in meeting assessed need and reduce the risk of requiring further support wherever possible. For example referrals are made to other services; Occupational Therapy, Continence Assessments or Telecare.

Changes to care packages may include an increase, reduction or a new service provision including community based resources. Any recommended changes to a care package are presented to a panel for consideration and validation.

On completion of the review a revised review report and care plan is provided to the Service User, their Next of Kin and any involved professionals. The review documents reflect current need and preferred outcomes with an outline of how the needs will be met to ensure the service user is safeguarded living in their local community.

Along with the review documentation a feedback form is included to gain quality assurance information and feedback on the review process.

The review team report safeguarding concerns and provide regular quality assurance feedback; liaising with both the Safeguarding and Monitoring Team to strive for best practice in the on-going support of vulnerable people in the local community.

Case Study A

David a 54 year old gentleman with physical disabilities and a mild learning disability who lived with his mother who was struggling to meet her son's personal care needs. David had become socially isolated and dependant on his recently bereaved mother.

The Reviewing Officer identified that the service user was in need of support along with his mother to prevent carer break down and the potential for David requiring 24hr residential care.

Following the Annual care review, respite care (short break) was offered to David which enabled his mother time to recover from a prolonged illness and engage the support of bereavement services. Further respite opportunities were put in place over the next 12 months to enable David's mother regular time away from the caring role. David also stated that he had benefited from the respite care as he felt supported and was able to meet new people whilst establishing new friendships.

In addition David was introduced to 1 day a week at a centre for people with physical disabilities. The day centre focused on independence and making full use of social opportunities supporting clients to go out and about in the community. Since attending this service David has broadened his social network and has become more socially active.

Since the review the whole situation has improved. David has become more independent and happy in himself, his confidence has returned and his mother is able to have more time to herself and take care of her own needs. David's mother was also offered support from Carers in Bedfordshire who now provide a befriending service.

Case Study B

Lynda is a 72 year old lady who was bed bound and dependant on 4 calls a day with 2 carers at each call due to multiple health problems and loss of independence with mobility and transfers. Lynda's husband was in crisis and was no longer coping with the home situation, due to complete carer break down; their relationship was also under immense strain.

The Reviewing Officer put in place the a number of referrals from the review: Occupational Therapy(OT) assessment of Lynda's living environment, equipment in place including a wheel chair and access in and out of the property. The OT was also asked to assess Lynda's mobility/transfer skills as it was felt she was more mobile

than she believed she was, due to total loss of confidence. Following the OT assessment Lynda felt more confident to transfer herself safely without the carers needing to be there, leading to greater independence and the care calls being reduced to once a day with 1 carer .

An Assisted Technology referral (Telecare) was made to assess Lynda for equipment to alert her husband when he was not in voice range if she required assistance. This technology reduced Lynda's anxiety of falling and not being able to get help and allaying her fears of not being able to raise the alarm in an emergency.

Respite care (short breaks) was sourced for Lynda which enabled her husband to have the time away from the caring role he needed. Lynda's husband was also provided with information on Carers in Bedfordshire for further support.

The home situation is now settled. Lynda and her husband feel more independent and less stressed with less care calls in place reducing stress, improving their relationship and quality of life

Comments, Compliments and Complaints

Our 'Comments, Compliments and Complaints' leaflet is given to all service users and carers following their assessment or review.

A total of 41 complaints were received in 2017/18. This compares to 24 recorded in 2016/17.

- Of the 41 complaints 23 were investigated under the Adult Social Care Statutory Complaints Procedure, and all were looked at under the local resolution stage.
- 18 complaints were investigated under the Corporate Complaints Procedure. 17 went through stage one, 4 of which were escalated to stage two and 1 went directly to stage two.
- 34 compliments, 33 enquiries, 4 comments 1 piece of anonymous feedback were also recorded.
- 6 decisions have been made by the Local Government & Social Care Ombudsman in this period.

Learning from complaints

There were 14 pieces of learning or recommendations recorded for complaints received in 2017/18. Here are a couple of examples:

- Recording sheets have been reviewed in terms of handovers and the new sheets which are more detailed in terms of logging service user concerns
- Staff have been reminded of the importance of passing information over to family members in a timely manner

Compliments

Compliments are important feedback that tell us what we are doing well and helps to spread good practice. 34 Compliments were recorded in 2017/18. Here are some examples:

- Compliment about 'wonderful treatment' from carers
- Compliment about help received to get adaptation works planned, started and completed
- Compliment about 'professionalism, kindness and deep sense of purpose' shown by residential care home staff
- Compliment about 'magnificent effort' undertaken for an Occupational Therapy assessment and consequent construction of a set of steps and rails.

Supported Employment Service for People with Learning Disabilities

The Supported Employment Service for people with learning disabilities continues to support a wide range of work experience and volunteering that prepares people for paid employment activities.

The service has continued to develop its person centred vocational profiling and making of easier to read job descriptions with employers.

Partnerships have also been developed to help with the transition of young people, to adulthood providing support and opportunities for individuals leaving education.

Many employers continue to be keen to support the service which has led to additional positions for example at Morrison's, Bedford Borough, Charterhouse and other companies in the local area.

The Supported Employment Service in April 2018 is supporting 90 people with learning disabilities:

- 28 in paid employment
- 13 in voluntary with incentive positions
- 34 in voluntary placements (some have more than 1 placement)
- 15 looking for work experience and paid employment.

Mental Health Partnership Board

In early 2018 a decision was made to develop a new Mental Health Partnership Board, to complement the existing forums run by East London Foundation Trust (ELFT), the specialist mental health provider. An initial meeting took place in March 2018 and the first full board is due to be held in June / July. The board has been developed around the successful Learning Disability and Older Person's Partnership Boards which are increasingly focused on attendee based agenda's. These agendas are theme based and focus on one or a set of linked themes such as local health and social care services, maintaining independence or employment and education opportunities.

The first partnership board will also focus on increasing membership and engaging with people who access mental health services within Bedford Borough. This work has been informed by close partnership working with ELFT, Healthwatch Bedford and local providers, amongst others. The other partnership boards have clearly demonstrated that the boards develop services and outcomes, for people who access the service positively and improve engagement with all parties. We look forward to supporting this development over the coming months.

Transitions -Thinking ahead and supporting individuals and family carers.

We know how difficult making the transition into adulthood can be for an individual and their Carers. In 2017/18 Bedford Borough Council's Adult Learning Disability Team (ALDT) made positive progress in ensuring confidence in the future planning for children, young people and their carers who require support under the Special Educational Needs and Disability (SEND) reforms. There has been a particular focus on the people who may potentially have significant need under the Care Act 2014, that may require support from adult social care when they reach the age of 18. In preparation for adulthood the service has developed tracking meetings with multi-disciplinary partners, including health, education and children's social care services to identify and monitor the progress of support for those affected by 'Preparing for Adulthood' (PFA). This in turn supports the future forecasting of care and support services, to provide a realistic projection of the presenting needs that may be required year on year, up to 2028 so that the market can be shaped and better equipped to understand and respond to those needs.

In 2017/18 the Team successfully appointed a PFA Advanced Practitioner in the ALDT who is a central point both as the strategic lead regarding future planning, as well as proactively supporting and developing the workforce's knowledge of key elements of law that impact directly on practice, for example the mental capacity legislation and deprivation of liberty safeguards.

This role provides support to other professionals involved with individual cases that have complex needs providing the steer and prompt for timely applications to Continuing Health Care (CHC). This assure systems are aligned and referrals for specific support services for health and social care needs are in place, ensuring we continue to improve the smooth transfer of care from children to adults.

Introducing this role has also been effective in establishing positive working relationships with families' carers and all our partners, to support and improve the experience of transition for the individual and everyone concerned.

2017/18 a full review of PFA protocol between children and adult services has been completed with our partners, including the Parent Carer Forum. This work was successfully co-produced in a meaningful way to provide a clear pathway when transitioning from child to adulthood.

A recent OFSTED inspection of children services recognised the progress made as well as the continued commitment in place to remain on target to achieve the outcomes for young people that will support the life long journey through to adulthood.

Delayed Transfer of Care

A delayed transfer of care occurs when a patient is ready for discharge from acute or non-acute care and is still occupying a bed.

During the year we continued to work closely with the local hospital to reduce delayed transfers of care wherever possible. This is an area where we have been very strong for a number of years, and this was reflected again in 2017/18 where we were top in the region for the lowest number of delayed transfers of care. This represents a huge achievement and one the organisation and all those working within the hospital social work team are rightly proud of. Over the next 12 months we plan to build on this success and to develop more innovative and collaborative ways of working to reduce the number even further.

Beyond the statistics the work is making real differences to individuals and the organisations concerned, with a low number of social care delays, the hospital are rightly able to focus their resources on those most in need.

Complex Needs Unit (Clarence House)

In March 2018 a new service opened its doors. The complex needs unit supports people with complex needs who are accessing both mental health and substance misuse services. Many of these people require specialist support to address a number of issue's including tenancy sustainability and homelessness.

The complex needs unit is state of the art in terms of both the quality of accommodation and the model of support provided within it. We have worked closely with the care provider, who has experience of running similar units, to tailor the offer to meet the needs of both the area and those who live within it. This places us in prime position to develop the service into one that is at the forefront of service delivery and support for the local area.

Care home refurbishment

Refurbishment works to upgrade 5 of the Bedford Borough owned residential homes for older people has continued throughout the last year. Works have included:

- installation of new entrances, ramps and receptions in the homes that have improved access for people with disabilities
- Window replacement programme in all homes, replacement flooring and redecoration of the home interiors with colour schemes chosen by residents
- Interior upgrade works at Puttenhoe and Parkside to improve the environment in communal areas, create space and enable easier garden access for residents
- Completion of the installation of new boilers which are more energy friendly and efficient

Residents at each home have been consulted fully throughout all of the works and resident and visitor feedback has been extremely positive regarding the upgraded homes. Works have been undertaken to ensure minimal disruption to residents of each home through comprehensive planning and consultation with each home by contractors and the property team.

Further works planned for completion this year include installation of additional elevators, replacement of fire doors and installation of new wet room facilities for residents.

9 . Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm

Adult safeguarding means protecting a person's right to live in safety, free from abuse and neglect. Adult safeguarding applies to any person aged 18 or over who has care and support needs, is experiencing or is at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from either the risk or the experience of abuse or neglect.

Abuse is a deliberate or unknowing mistreatment by any other person or persons that causes harm to a person or violates a person's human and civil rights. The abuse can vary from treating someone with disrespect in a way which significantly affects their quality of life, to causing actual physical suffering.

The Care Act 2014 statutory guidance states that safeguarding should be personal; it should be person led and outcome focused; it should enhance involvement, choice and control as well as improving quality of life, wellbeing and safety.

6 key principals underpin all adult safeguarding work

- Empowerment
- Protection
- Prevention
- Proportionality
- Partnership
- Accountability

The Care Act 2014 states that local authorities must make enquires, or cause others to do so, if they reasonably suspect an adult with care and support needs is, or is at risk of being abused or neglected.

The purpose of an enquiry is to decide whether or not the local authority or another organisation or person should do something to help and protect the adult.

The safeguarding duties (three stage test) apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

The objectives of an enquiry into abuse or neglect are to:

- establish facts;
- ascertain the adult's views and wishes;
- assess the needs of the adult for protection, support and redress and how they might be met;
- protect from the abuse and neglect, in accordance with the wishes of the adult;
- make decisions as to what follow-up action should be taken with

regard to the person or organisation responsible for the abuse or neglect; and

- enable the adult to achieve resolution and recovery.

Where an individual does not have the mental capacity to decide how to protect them self from abuse, organisations will actively use legislative frameworks to protect that person and an Independent Mental Capacity Advocate must be sought to represent their interests during adult protection procedures.

When a safeguarding concern is received by the Safeguarding Team, initial enquires are made to decide what action is required and whether a Section 42 Safeguarding Enquiry should be implemented under the Multi Agency Safeguarding of Vulnerable Adults policy. For 2017/18, the Safeguarding Team received 1436 safeguarding concerns of which 212 resulted in safeguarding initial enquires being made and as a result of the initial enquires 42 were raised to a formal Section 42 Safeguarding Enquiry. Of the 1394 initial enquires that did not progress to a formal Section 42 Safeguarding Enquiry, actions such as care management involvement, reviews of care packages, risk assessments and actions for providers were put in place.

From our knowledge of these cases we have no reason to believe that more people are at risk of significant harm, rather that detection and awareness continues to improve. Enquires lead to a wide range of outcomes resulting in the person being safeguarded.

There has been an increase in the number of domestic abuse cases reported to the team. This is likely to be a result of a much greater awareness of domestic abuse due to awareness raising campaigns among both the public and professionals.

Contacts to the safeguarding team continue to rise, many of the contacts/concerns the team receive are not treated under safeguarding and indicate a risk but not a safeguarding concern, and are forwarded to the most appropriate agency to support/deal with the concern. This is an area where there is ongoing work with partner agencies to ensure contact with the safeguarding team is relevant and appropriate, meaning that the team can focus support to those at risk of abuse.

Section 42 enquiries by type of abuse

Type	2013/14	2014/15	2015/16	2016/17	2017/18
Physical	88	60	34	23	26
Discriminatory	3	1	-	0	0
Neglect	214	124	56	68	65
Sexual	31	24	17	13	32
Emotional/Psychological	89	27	20	9	14
Financial	93	45	21	19	49
Institutional	7	6	4	0	0
Domestic Abuse	-	-	-	5	26
Total	**525**	**287**	**152**	**137**	**212**

The above figures show that the least intrusive response has been considered since the implementation of the Care Act 2014, against the risks presented.

Case Study A

Jane

Concerns were received from the ambulance service and police, when 'Jane' was admitted to hospital following self-harm. Jane lacked mental capacity and was unable to express her wishes for the safeguarding she wished to achieve, Initial thoughts were that Jane could not return home to the residential/nursing provision she had resided at since 2009 due to the suspicion that injuries were not self-injurious.

A thorough safeguarding enquiry was completed, which was able to establish there was no abuse and Jane was able to return to her residence with no disruption to ongoing care and relationships. Support was offered regarding preventative approaches to self-harming for the future.

Case Study B

Sarah

Sarah had complex needs and lived in the community with members of her family and had expressed concerns to her care manager and others about the controlling nature of her family, especially with her money.

Sarah reported she was not allowed to manage her own finances or have extra money for items of her choosing.

As part of the S.42 safeguarding enquiry the outcomes Sarah said she wanted to achieve were to live away from her family members and have more choice over many things including how and what she spends her money on. Sarah had mental capacity to make the aforementioned decisions. Sarah was supported to move into residential accommodation and have more choice and control in regards to important matters in her life.

Sarah has fed back to her care manager that this has changed her life, she has now established more and deeper friendships; she has the opportunity to engage in more day and evening activities of her choosing and she also has much greater choice over how and what her money is spent on. As an example when coming into residential care Sarah had very little clothing, and now has an extensive wardrobe with items of her choosing.

Mental Capacity Act 2005 Deprivation of Liberty Safeguards

The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. If a person is stopped from doing the things they want all the time, this is called being deprived of their liberty. Sometimes people having treatment or care might be deprived of their liberty to keep them safe. When a care home or hospital needs to stop people from doing something in this way they need to apply for authorisation through Deprivation of Liberty Safeguards (DoLS) from their local authority and show they are acting in a person's best interest. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom.

Following a Supreme Court Ruling in 2014 which increased the safeguard thresholds Bedford Borough Council continues to receive a large numbers of requests to assess people under the Deprivation of Liberty Safeguards.

For 2017/18, a 5% increase was observed with a total of 1319 requests. The breakdown of the requests per quarter is as follows:

Number of Applications received per quarter 2017/18

April to June 2017	313
July to September 2017	320
October to December 2017	319
January to March 2018	367
Total	1319
% of All DoLS authorisation applications completed at end of 31/03/2018	95%

Nationally, the number of requests continues to rise with a large number of Local Authorities (known as the Supervisory Bodies) experiencing a back log of cases. For 2016/17 there was a reported backlog of 108,545 cases in England. To date, Bedford Borough Council is very proud to not have a back log and this has been the case since the ruling in 2014.

According to national statistics for 2016/17, the average number of days from applications being received to being completed across

England was 120 days. This means that many people assessed under the safeguards are potentially subject to a period of unlawful deprivation, if a decision is made that a standard authorisation is required to lawfully deprive of liberty. Bedford Borough Council continues to be committed to ensuring assessments are undertaken within the statutory timescales; for 2017/18 a total of 11.4% cases resulted in persons being subject to a period of unlawful deprivation.

There are a number of reasons as to why Bedford Borough has been able to continue to manage these demands including:

- Continued support from Council Leaders and Senior Officers with regards to securing the Human Rights of people who lack capacity to consent to their care and support in care home and hospital settings. DoLS remains a priority agenda item and updates are provided via a number of forums, for example, the Safeguarding Adults Board with focus on local, regional and national practice.
- A supportive and committed pool of Approved Doctors (specially trained, referred to as Section 12 Doctors) and Best Interests Assessors (Specially Trained Professionals).
- Regular professional practice supervision providing an opportunity to share knowledge and reflect on best practice.
- An efficient and robust DoLS process. There is a dedicated team that focuses on all DoLS related activity. A signatory DoLS rota is in place which ensures that assessments are scrutinised and authorisations are granted/not granted in a timely manner.
- Partnership working with Care Homes and Hospitals (known as Managing Authorities). The team has developed good networks with all local providers required to submit authorisation requests and support is available to manage and respond to queries.

Collaborative working with neighbouring Supervisory Bodies, the Eastern Region and our advocacy service (POhWER)

Domestic Abuse Strategy

We consider Domestic Abuse as everyone's business. Our vision is to create a society in Bedford Borough where domestic abuse is not tolerated, and to reduce the level and impact of incidents in the Council area.

Domestic abuse is defined by the UK government as 'any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse'.

Controlling behaviour is defined as 'a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities

for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.'

Coercive behaviour is 'an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'.

A report commissioned by the Council found that there were 3,137 domestic abuse incidents reported to the police in 2014/15 in Bedford Borough, which is relatively high considering its population. It is estimated that there are approximately 4,900 victims aged 16 and older in Bedford Borough, based on the prevalence of domestic abuse in England and Wales. Despite there being an average of 100 calls a minute to the police being made nationally, domestic abuse remains a hidden crime, with many victims still not coming forward. On average, only 37% of victims tell someone in an official position about the abuse they experience, with only 4% telling a specialist support service. Many more adults and children will be hidden victims because of under-reporting due to perceived stigma and shame.

A New Bedford Borough Council strategy to tackle the causes and effects of Domestic Abuse (2017 – 2021) was approved in July 2017. The Strategy was developed using the research which the Council commissioned 'SafeLives' (a specialist domestic abuse organisation) to undertake. The strategy is an essential step to ensure a coordinated approach across the Council and partners, tackling the causes and effects of Domestic Abuse.

Web pages: www.bedford.gov.uk/advice_and_benefits/domestic_abuse.aspx

The Borough has developed a structured and co-ordinated approach to domestic abuse with strategic aims:-

Governance: The Borough has a structured and co-ordinated approach to domestic abuse.

A clear structure has been put in place whereby a Multi-agency Operational Delivery Group has been created, which is made up of representatives from Children's Services, Adults' Services, Environmental Services and our statutory partners in Health, Criminal Justice and the Voluntary Sector. Our operational lead is also linked into the Bedfordshire Domestic Abuse Partnership Forum.

In terms of safeguarding, this structure ensures that the responsibility is shared throughout the Council and a whole family approach to domestic abuse is considered, including the direct victim of the abuse and the perpetrator as well as any children impacted by the abuse. It also means that there are direct links into other Strategic Boards such as Adult Safeguarding Board, Children's Safeguarding Board, Community Safety Board and the Health and Wellbeing Board to incorporate actions into relevant strategies and ensures a joined up approach to Domestic Abuse.

Partnership: To bring together all those involved in the domestic abuse agenda to achieve shared goals and outcomes.

The Council has been working with our neighbouring authority on a joint tender to commission some perpetrator services within Bedford Borough. The successful bidder was The Change Project. The Change Project will provide a group work programme as well as a 1-1 programme which is (subject to meeting the criteria) suitable for female perpetrators, those whose first language may not be English, Bisexual, Gay Lesbian and Transgender (BGLT) relationships, and those with reading difficulties. As well as both of these programmes there will be an outreach perpetrator worker who will be based in Bedford Borough one day a week and will be available to support staff in working with perpetrators.

Provision: A range of high quality services are available to meet the needs of victims, their families and perpetrators.

A large proportion of domestic abuse provision is carried out by the voluntary sector within the Borough, with whom we work very closely.

Prevention: We want to ensure support is available to prevent domestic abuse and intervene at the earliest stage to prevent escalation.

This will mean that victims, children and perpetrators are identified early and referred appropriately by a wide range of frontline practitioners and partner agencies; that victims are supported to recover, build resilience and not to tolerate domestic abuse in the future, and that young people are able to recognise if they are in an unhealthy relationship and know how to access support.

10. Workforce, Commissioning and Partnerships

Community Health Services

During 2017 Bedford Borough Council's Adult Social Care Services worked in partnership with neighbouring authorities and Bedfordshire Clinical Commissioning Group, who led on an extensive procurement programme regarding Community Health Services. The five-year contract will be delivered by East London Foundation Trust (ELFT) in partnership with Cambridgeshire Community Services NHS Trust (CCS) and will commence on 1st April 2018. The contract will cover a range of adult and children's community health and care services and other specialist services including nutrition and dietetics, podiatry services, wheelchair services, community dental services, as well as drug and alcohol services for children and young people.

This contract enables us to continue delivering high quality health and social care services to local people that will be safe, fit for purpose and sustainable

The new contract which is based on the delivery of agreed outcomes, aims to transform community services, support the sustainability of primary care and the acute sector and ensure patients will receive care that is centred on their needs, co-ordinated through integrated multi-disciplinary teams and delivered within the community closer to home.

The new Bedfordshire Community Health Service will provide:

- High quality, personalised care, which enables people, including those with chronic conditions, to live independent, active, healthy, happy lives closer to home.
- Services designed around, and by, empowered patients. These will be place-based with multi-professional Primary Care Home teams integrating voluntary sector, health and social care.
- Children and Young People's services that are child and family focused (needs led), integrated, accessible and flexible, with a focus on early intervention and prevention.

Better Care Fund

We are very proud to report that each year sees improvements towards integration with health and social care services. 2017/18 has continued to build upon the strong foundations developed in previous years.

The driving force to improvements has been a result of the appetite for collaborative working supported at all levels of Bedford Borough Council and Bedfordshire Clinical Commissioning Group. This includes more formal stakeholder Boards including the BCF Partnership Board, the Bedford Borough Health and Care Transformation Group and the A & E Delivery Board.

The financial contribution contained in the Better Care Fund has supported a number of business as usual components these include rehabilitation and reablement, carers support services, falls services, a proportion of the community health services and much more. These have continued to provide valuable services to Bedford Borough residents.

During 2016/17, we made improvements to collaborative working across health and social care and in 2017/18 we expanded some of these schemes to increase access. These include:

End of Life:

- Increased joint working and communication across community nursing teams and social care teams
- An operational end of life group has been in place during 2017/18 inclusive of health and social care operational staff. This tackles issues and improves pathways in a timely and joined up way.
- Increased focus across health and social care on Advanced Care Planning (ACP). This has led to increases in the number of ACP discussions i.e. people nearing the end of life discussing their wishes and feelings in terms of where they wish to be cared for.
- We have expanded the service provided to service users from the Palliative Care Hub (formerly PEPS). This now includes 24/7 365 days a year service to those nearing the end stages of life, including their family and carers. It includes response for crisis intervention, planned visits for support and night sitting.
- A new pathway was jointly developed by the operational group and has been successfully launched across Bedford. This provides vital support to people and their families in their last weeks of life. The aim is to support people to remain at home with their loved ones in an environment familiar to them whilst reiving the care they need from highly trained professionals.
- During this last year, we launched the compassionate communities' initiative. Interest has been shown from various support groups across the Bedford community to champion the initiative.

Falls:

- More staff were funded and recruited to increase the capacity in the first Response Falls service in order to deliver a seven day service.
- A fracture liaison service was established at Bedford Hospital.
- Continuation of delivery of strength and balance services to the Bedford community which are very well attended.
- Chair based exercises in residential homes to support reduction in falls. This has been very well received and attended.
- Reporting shows a decrease in the number of hospital admissions due to falls which is as a result of all the interventions.

Stroke Early Supported Discharge:

- We established a joint health and social care pathway to support people who need both health and social care intervention to be discharged from hospital sooner and receive the care and support they need in their own home environment.
- Since implementation, this service has consistently been operating at capacity which demonstrates that people are receiving the care they need in a timely way.
- The implementation of the service has meant that people have been discharged sooner from hospital. The results of this new pathway is showing that patients are achieving their goals quicker in their own homes.

Joint Rehabilitation and Enablement:

- Teams across three different organisations have been collocated to create joint pathways.
- Three separate assessments and paperwork were re-designed forming single assessments, processes and paperwork. This reduces a lot of duplication which increases the time that the staff are able to support patients using the service.
- Reporting shows an increase in the number of people being seen by the service due to joint working.
- Due to joint communication processes across the new pathway, service provision is more streamlined and patients are seen quicker.

British Red Cross Home Support and Reablement Service:

- Funding was increased due to demand on service and impact of delivery
- This is an excellent service providing support to people who are discharged and leaving hospital. The service settles people back into their own home and increases confidence and independence. Includes home from hospital, home support and reablement service.
- Prevents readmission and supports timely discharge from hospital
- In first 3 quarters of 2017/18, the service supported 242 people. 94% reported improved ability to manage day to day activities

Stroke Recovery Service:

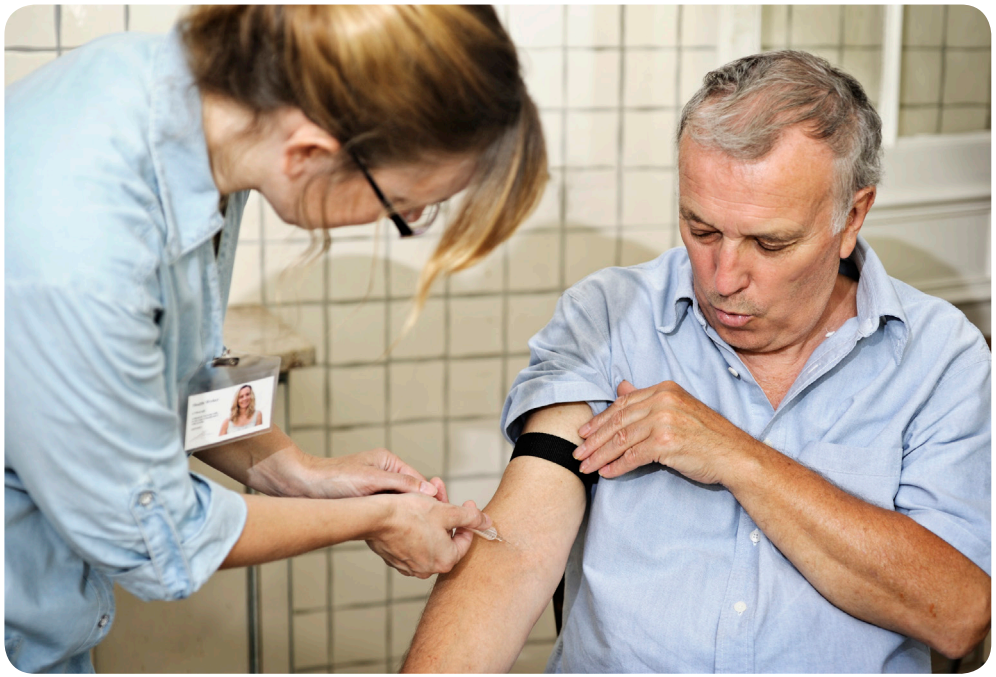
- Increased funding has been provided to the Stroke recovery service. They have been delivering holistic reviews to people who suffered a stroke six months previous. Reporting demonstrates high percentages of achieved outcomes for patients.
- This scheme supports reducing hospital readmissions and shorter length of stay.
- During Q1, 2 and 3, 266 people reported improved outcomes for the information, advice, support and prevention element of the service.
- During Q1, 2 and 3, 188 people reported improved outcomes following a 6 monthly review.

Implementation of new schemes

Due to some additional funding we were able to implement a number of new initiatives during 2017/18. These included:

Scheme	Description
Hospital based Independent Domestic Violence Advisor (IDVA)	Service supports a reduction hospital admissions through: • High number of first time referrals/victims being identified and supported • The increased awareness of domestic abuse across the hospital due to proactive and continued communication and engagement, training and visibility • Research suggests a high proportion of victims attend A&E 15 times each
Additional Therapy input into Winter Beds	BCF has funded therapy in additional beds purchased to alleviate winter pressures. This has enabled people to regain independence and move on more quickly. 72 patients have transferred into the winter beds since November 2017, all of which would have required therapy input.
Carers UK digital Resource	The carers digital platform supports and empowers carers with the information, signposting and skills they need to continue to care for their loved ones at home, which reduces reliance on health and social care services. Since in place, it's seen a number of carers registering with the site and accessing the carers platforms.
Carers sitting service	Started in November 2017. Very valued by carers.
Additional resources to support dementia peer support groups, activity groups and memory programme.	This additional resource to the dementia programme has impacted by increasing resources to do more around helping people with dementia live well in the community, reduce carer breakdown, reduce A&E attendances. The role is pivotal in maintaining contact with carers and people living with dementia.
Mental Health Peer Support programme	5 learners have completed the programme. Reporting shows an overall improvement of 59% using the PHQ9 scale and 53% improvement using the GAD7 measuring scale. The majority of the learners are already supporting each other in their communities as peers.

Scheme	Description
Care Home Schemes:- Assistive Technology in care homes:	Includes Inflating balloons provided to care homes to help people to stand. Wander mats provided to care homes, to alert staff.
Trusted Assessor and Project Officer Post:	Both roles are in place. Reporting shows these are making a significant impact and helping clients move more quickly back to where they want to be.



Developing the workforce

Staff remain key to delivering excellent outcomes for people. This includes staff in organisations that we commission to undertake tasks for Bedford Borough Council, as well as those that we directly employ. Across the sector there remains a healthy demand for training that the Council provides free of charge to the care workforce, as well as family carers and Personal Assistants.

Regular training courses are available on core topics such as Safeguarding, Mental Capacity and Deprivation of Liberty. New opportunities in 2017/18 included:

- Training for Providers Section 42 Enquiries
- Challenges of Self Neglect in Safeguarding
- Safeguarding and the Mental Capacity Act
- Advanced Chairing Decision Making
- Appropriate Adult
- Safeguarding responsibilities for Support Workers

Approximately 100 training activities, events and qualification programmes were accessed with 45% of participants being employees from the Private, Voluntary and Independent sector. Whilst the number of events have reduced, Bedford Borough Council has focused in on ensuring that key subjects are covered and the quality of provision is maintained to a high standard.

11. What we are proud of!

We are proud of a number of areas of activity, but would like to mention two.

1. Care Standards Monitoring Service

Through the development of the Council's Care Standards Monitoring service we have been able to build positive transparent relationships with our care providers be it Domiciliary Care Agencies or Care homes. Our ethos is to support the provider to maintain the quality care we as commissioners expect and ensure are in line with Care Quality Commission regulations and current legislation.

The Care Standards Monitoring service have recently piloted the Provider Assessments and Marketing Management System (PAMMS) which has been introduced into the ADASS eastern region, this provides the council with not only evidence based quality monitoring but also analytical and workflow management. So far the outcomes have been positive and one domiciliary care agency achieving an excellent rating.

For the year of 2017 the team responded to 242 Quality Assurance reports in some cases this will have been to recognise good practice by our providers. The information from Quality Assurance reports is used to gain soft intelligence regarding our providers, with this and our close working partnership with the Bedford Borough Safeguarding Team this enables the Council to have a proactive approach with our providers and prevent provider failure.

2. Best in the country for lowest number of Delayed Discharges

Adults Social Care

A key focus for work in Adult Social Care is coordinated care and support across the health and social care system. This is why in 2017 we co-located the Council's Hospital Social Work Team within Bedford Hospital to sit alongside the Community Health and Discharge Navigators, to ensure a coordinated approach to receive timely referrals for social care discharges so as to plan their homeward journey.

At the end of 2017/18 through hard work and dedication our Hospital Social Work Team 7 day a week service was ranked in the regional benchmark the 1st out of 11 local authorities and provisional end of year data for 2017/18 suggests that Bedford Borough was ranked 1st nationally for the number of DTOC against 151 local authorities for supporting people back home in a safe and timely manner, ensuring they had the support they needed to return home with their needs met safely.

This is fantastic news as it has not only helped local people to get home, but has helped our local hospital to manage the increasing and complex demand faced. We intend to keep up the good work!

System-wide DTOC Target

The Bedford Borough Delayed Transfers of Care (DTOC) target for 2017/18 was 3,364 (system-wide) for Health and Social Care. The latest figures (unconfirmed at this time) suggest that Bedford Borough will not only achieve, but exceed this challenging target.

The provisional outturn is expected to be 3,266 meaning that the year-end target will have been met/exceeded by 3% or 98 DTOC. Bedford Borough will have improved DTOC by 30% compared to the previous year (the outturn in 2016/17 was 4664 DTOC).

12. Priorities for 2018/19

Our key priorities for 2018/19 will be to:-

1. Continue to collaborate and join up health and social care services for the best outcomes of our shared local population.

2. Continue to build and strengthen communities through early help and personalisation; increase the uptake of direct payments, and build on our Local Community Coordination and strength based approaches to protect an individual's independence, resilience and ability to make choices and maintain wellbeing. Supporting a person's strengths can help address needs for support in a way that allows the person to lead, and be in control of, an ordinary and independent day-to-day life as much as possible.

3. Increase the numbers of carers receiving an assessment or a review and assure that information and advice is readily available.

4. Monitor and where possible reduce the number of admissions to residential care for younger adults (18-64) and continue to monitor the reduction of residential care for people aged 65 and over.

5. Continue to build on our good work with younger adults to assist them in 'Preparing for Adulthood' by working closely with our partners in children's services, our independent living team, education partners and our local supported employment scheme.

6. Work with all partners to assure that we continue to keep vulnerable people safe. We will also review referral pathways so we can continue to direct our safeguarding resources to those who are at risk of abuse, and to assure that we make safeguarding personal at all times. Our practice is to put individuals in full control of the safeguarding process, involving them every step of the way in terms of how the issue is investigated, and what action is taken as a result. Going through a safeguarding process can be very traumatic for some people and our aim is to put the power back into individuals' hands through a fully personalised service. Not only does this ensure that we achieve the outcome/s that the individual wants, but also allows people to have a positive experience of a process that respects their views and wishes, supports their wellbeing, promotes their independence, and ultimately makes a positive impact on their life.

12. Glossary of Terms

An alphabetical explanation and meaning of some of the terminology used in the Local Account.

Better Care Fund (BCF)
The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible.

Clinical Commissioning Group (CCG)
A group of GP practices in a particular area that work together to plan and design health services in that area. Each CCG is given a budget from NHS England to spend on a wide range of services that include hospital care, rehabilitation and community-based. Your local CCG should work with the council and local community groups to ensure that the needs of local people are being met.

Direct Payments
Cash payments given to people to pay for the community care services they have been assessed as needing. They are intended to give people greater choice in their care. The payment must be sufficient to enable the person to purchase services to meet their needs and must be spent on services that he or she needs.

Eligibility Criteria
Guidance has been issued from the Department of Health about how each Council should set they criteria they use for a person to be eligible for social care services. Councils should ensure that each decision about a person's eligibility for support is taken following an appropriate community care assessment.

Health and Wellbeing Board
The government is proposing that local authorities which have a duty to set up these Boards. The aim is to bring together local councillors, patient representatives and key decision-makers across health and social care so that local people benefit from coordinated and joined up local services. There is to be a focus on addressing health inequalities, combining resources across health and social care, and the empowerment and involvement of local people.

Healthwatch
Healthwatch Bedford Borough is the local consumer champion for publicly funded health and social care. The aim of the local Healthwatch is to give citizens and communities a stronger voice to influence and challenge how health and social care services are provided within their locality.

Joint Strategic Needs Assessment (JSNA)
The Local Government and Public Involvement in Health Act 2007 places a duty on local authorities and CCGs to undertake these assessments. This is a process to identify current and future health and well-being needs of the local population; informing the priorities and targets set by local authorities and the local NHS CCGs. It enables agreed commissioning priorities that will improve outcomes and reduce health inequalities.

NHS continuing care funding
This describes a package of continuing health care provided outside hospital, arranged and funded solely by the NHS, for people with ongoing healthcare needs. To decide if a person is eligible for this funding an assessment of healthcare needs takes place. Eligibility for continuing care funding is reviewed on a regular basis.

Personal Budgets
An allocation of funding given to users of community care services after a community care assessment. The amount should be enough to meet their assessed needs. People can take them either as direct payments (see above) or – while choosing how their care needs are met and by whom - leave local authorities with the responsibility to commission the services; or they can have a combination of the two.

Personalisation
Personalisation is a social care approach described by the Department of Health as meaning that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings". The purpose is to ensure that services are tailored to the needs of every individual, rather than being delivered in a "one-size-fits-all" fashion.

Reablement
Services for people with poor physical or mental health to help them accommodate their illness by learning or re-learning the skills necessary for daily living. The aim is that, through short term intervention, people are helped to recover skills and confidence to enable them to live at home.

Self Directed Support
A description of how a Council plans to arrange social care support by carrying out an assessment of need with an individual; agreeing what help is needed and then determining how much money will be provided to pay for it. This is called a personal budget. The Council then agrees a plan with an individual about how the money will be spent and who will manage the "personal budget". Some people choose to manage the money themselves.

ELFT- East London NHS Foundation Trust
ELFT is commissioned by Bedford Borough Council to provide mental health social care services in Bedford Borough. ELFT also provide Bedfordshire Community Health Services.

Notes

Finding out more

If you would like further copies or information about us and our services, please telephone or write to us at our address below.

Për Informacion	برای اطلاع	তথ্যের জন্য
للمعلومات	Per Informazione	ਜਾਣਕਾਰੀ ਲਈ
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