

Adult Social Care Our Vision



beam

because **Every Adult Matters**



FOREWORD



I am proud to be the cabinet member for Adult Social Care and Community Health in Buckinghamshire, and to be part of a service that is innovative and forward thinking.

As a portfolio team we have a great deal to be proud of, but there is still more that we want to achieve.

In this paper we describe Buckinghamshire County Council’s commitment to its most vulnerable adult residents and we set out the services our residents use or may use in the future.

Most importantly, it describes how the vision for Adult Social Care will be translated into reality for people living in Buckinghamshire and how this is encapsulated within our strategic framework and underpinning philosophy of **bEAM** (**b**ecause **E**very **A**dult **M**atters).

I trust you will find the following pages both informative and inspiring reading.

A handwritten signature in black ink, appearing to read 'Mike Colston'. The signature is stylized and cursive, with a long horizontal line extending to the right.

Mike Colston
Cabinet Member Adult Social Care

INTRODUCTION

This paper is designed to inform and inspire all adult client groups and aims to clarify the **bEAM** (**b**ecause **E**very **A**dult **M**atters) message. It is primarily for our staff and partners and explains what our Adult Social Care portfolio is trying to achieve and how we will go about doing this.

It is organised around six themes:

- The vision and strategic framework
- Our context
- Where we have come from
- What we have achieved
- How we continue to modernise services
- The future – where we are going next

THE VISION AND STRATEGIC FRAMEWORK

bEAM is the overarching vision and strategic framework for adult social care. Formally launched in October 2007, **bEAM** brought together and extended a number of previous strategies including Building Bridges to Independence and Thirst for Life. **bEAM** has evolved through consultation with staff and users. It establishes the philosophy for service development and modernisation in Buckinghamshire and is consistent with major national policy programmes such as *Our Health, Our Care, Our Say, Valuing People Now* and the *Transforming Social Care Agenda*.
(Appendix A of this document sets out on one page the Headline Vision Statement.)

bEAM IS NOT A SERVICE
IT IS ABOUT EVERYTHING WE DO
From enabling independent living to promoting dignity in care; and from safeguarding vulnerable adults to enhancing health and well-being.

OUR CONTEXT

Our Population ...

Buckinghamshire's population is approximately 479,000 people, of which 15% are 65 and over. By 2026 it is estimated that 65+ years age group will grow as a proportion of the total number of people living in Buckinghamshire to 20%.

People who come from Black and Minority Ethnic groups make up 8% of the population of Buckinghamshire as a whole. Overall, Wycombe district has the highest population (12.1%), followed by South Bucks (6.6%), Aylesbury Vale (5.9%), and Chiltern (4.5%).

With respect to health and disability, 13% of people in the county are reported to having limiting long term illnesses compared to 18% in England and 15% in the South East.

The Buckinghamshire population has a higher life expectancy than the national average.

Overall, Buckinghamshire is relatively wealthy, with average household income around 30% higher than the UK average. Because of this a significant number of people pay for their own social care. It is estimated that up to 48% of residential beds and 38% of nursing beds are occupied by self funders. There are proportionately more self funders in Buckinghamshire than in England as a whole.

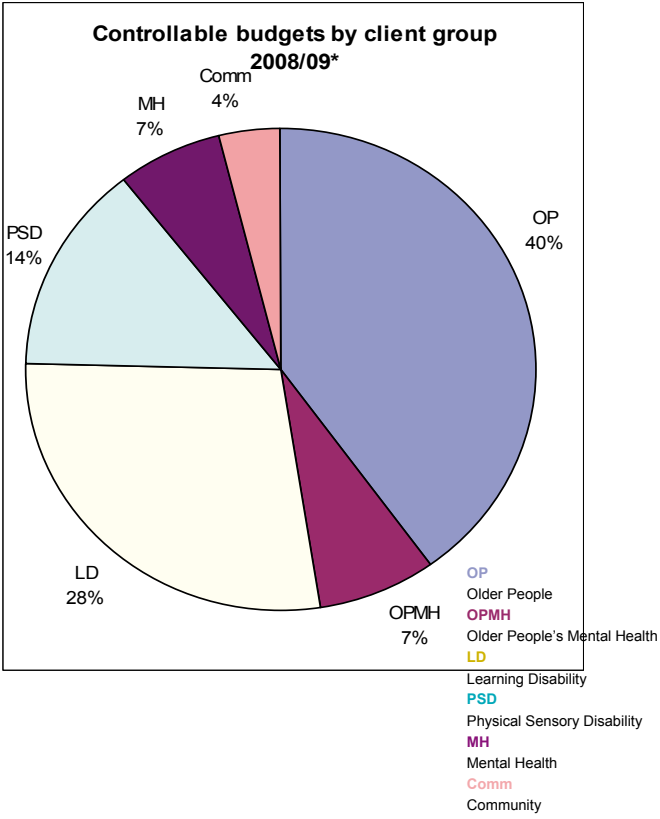
Whilst much of Buckinghamshire is affluent, small areas of relative deprivation do exist. One percent of the population live within areas that are in the 30% most disadvantaged in the country.

The county faces challenges in seeking to meet the diverse needs of urban and rural communities and different user groups, particularly those experiencing significant relative deprivation.

To ensure that we fully understand the needs of people living in the county, we are working with a multi agency Buckinghamshire Healthy Communities Partnership – led by Cllr Mike Colston - to undertake a Joint Strategic Needs Assessment. This will be regularly updated.

Our Financial Position ...

In 2008/09 we will spend just over £88 million. The following chart shows the distribution between client groups.

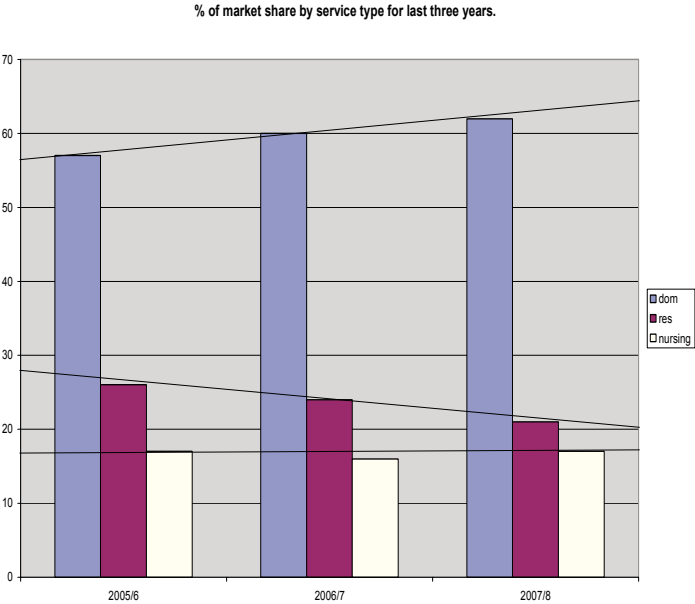


* Supporting People is fully funded by grant £5,588,000

Our financial position continues to be challenging with a requirement to constantly deliver efficiency savings. And given increasing demand, rising expectations and our wish to do more, we have to find new ways of making the money go even further to improve outcomes. For example, Cllr Mike Colston is working on South East Efficiency and Improvement Partnership as the ASC lead for South East Counties seeking new ways of delivering savings and improving services.

Our Market Share

Consultation both nationally and locally has shown that individuals prefer to remain in their own homes rather than receive support in a residential or nursing home. Bucks County Council has reflected this as shown in the following graph which illustrates continued growth in individuals receiving home support whilst demonstrating a reduction in the use of institutional care.



Value for Money ...

Over the past six years, we have delivered value for money by providing low cost yet high quality services.

We have lived within available resources and not once over spent the budget. This is an important discipline which will continue.

Our ongoing approach includes:

- Effective budgetary management
- Efficient use of block contracts
- Reducing our reliance on agency staff, and
- Service redesign
- Use of direct payments to foster independence and choice

Use of Technology ...

We are also making much better use of Information Technology. For example:

- Extending the use of mobile technologies to record client assessments in people's own homes.
 - Using telecare equipment to help people remain independent and enable them to remain living in their own home.
 - Improving and integrating back office systems to ensure greater financial and data quality control.
-

WHERE WE HAVE COME FROM

As a portfolio, our approach to adult social care has been informed by the County Council aims of:

- Improving the quality of life for adults
- Providing support to help families cope with their responsibilities
- Building safer, stronger and healthier communities

In recent years, we have been very good at providing services to those in greatest need (critical and substantial FACS¹ banding), good at managing our budgets and good at providing high quality preventative services through our partnerships with the voluntary sector.

We have also benefited from productive partnerships with health and our District Councils.

And in line with the ethos of the council, we have avoided providing services that create dependency, preferring instead to concentrate our efforts on promoting safe independence, self help, support to carers and support to communities.

WHAT WE HAVE ACHIEVED

As a result of where we have come from and the **bEAM** philosophy, we have seen some big changes to the way services are delivered:

- **Increased the range of housing and support for people in their own homes:** For example, by 2006 moved 52 people with a learning disability from NHS inpatients services where they had been living for many years into new models of supported living services in the community (Project Abode). We are also achieving our goal of moving people with severe and enduring mental health difficulties from residential care into new supported living units with their own front door by 2010. In addition, our 24-14 service is enabling individuals to return and live at home after a hospital admission - rather than stay in hospital or have to live in residential care.
- **Kept more people out of hospital:** Examples include Crisis Resolution and Home Treatment in Mental Health Services, an increase in the number of step-down beds and a higher limit for intensified care packages.
- **Increased people's choice and control over their own lives:** Examples include Direct Payments (678 adults on 5 March 2008), In-control, and Person Centred Planning.

- **A greater focus on preventative services:** Through better targeted early interventions that prevent the need for more intensive support and preserve the dignity and control of Buckinghamshire residents. We provide preventative services across three tiers²: Examples include In-Touch, Time 4 You, and Helping You to Shop.
- **Increased integration of services with our partners:** Such as the Care Programme Approach (CPA); we have joined with our NHS PCT to establish two lead commissioning, pooled budget agreements for LD and Adult Mental Health; and the establishment of two pooled budget agreements (S.75) for integrated provision between ourselves and the Oxfordshire and Buckinghamshire Mental Health Trust for adults and older people with mental health difficulties. All of these arrangements enable us to commission and provide services for people in a more integrated and joined up way across Adult Social Care.
- **Support for carers:** In March 2006 there were 3,961 carers receiving support from Carers Bucks. By December 2007 this figure had increased to 5,954 representing an improvement of over 50%.
- **Helping more people to feel socially included:** Examples include supporting people back to work, employment of service users within the council (Aylesbury Re-Use and Recycling Centre (ARRC) and Watergarden) and Creative Solutions – a service which enables disabled people to access leisure and other community based activities.

- **Providing services to B&ME communities:** Examples include a dedicated lead worker who has been successful in reaching the Gypsy, Roma and Traveller community groups within the county. Also through Creative Solutions we are reaching individuals within the B&ME communities. Additional case studies include the Haroun Day Centre providing monthly care management surgeries for the black Caribbean community; and The Saheli project which is providing day opportunity support for young Asian women who have difficulty accessing services due to their families concerns regarding maintaining certain aspects of their culture.
- **Establishing 19 GC2C links:** We are achieving more effective community engagement, local decision making and joined up local services. During 2008/ 09 we will be holding social work surgeries quarterly in libraries and venues which will be open to all.
- **Strengthening our approach to safeguarding vulnerable adults:** We have increased our commitment to safeguarding vulnerable adults through increased investment and planning with our partners to improve the way we work together. The creation of the Buckinghamshire Safeguarding Board, with an independent chair, and new investment in carefully targeted training will ensure that we begin the process of improvement and modernisation of our safeguarding systems to benefit our most vulnerable citizens.
- **Voluntary/community sector development:** We have a dedicated project team to support the voluntary and community sector. This will cover community development; prevention project co-ordination; and the development of a community database.

CASE STUDIES*

In-touch provides a telephone based service for adults who are finding it difficult to maintain independent living as a result of disability, illness, age, or social exclusion. It provides community specific information and advice that enables people to make their own informed choices, and encourages preventative care.

These are just some of what our users have had to say about In-touch:

“It’s nice to know that someone cares.”

“I feel secure and supported with regular phone calls.”

“It’s nice that I’m not being left alone.”

“Most helpful person I’ve spoken to.”

“What an extraordinary good service.”



Our **24/14 service** enables vulnerable and disabled adults to return to safe independent home living as soon as possible after hospital admissions. The 24 hour/14 day service supports people with up to two weeks intensive home care - which includes a live in carer and domiciliary care. Resident Hilda is one such recipient of this service when a fall left her with a fractured knee. Hilda has severe arthritis and lives with her husband who has cognitive problems. After her fall, she was unable to cope at home but did not want to stay in hospital. 24/14 placed a live in carer at her home during which time she was able to be with her husband and readjust her daily routine. Together with a care worker and occupational therapist, some of the physical and emotional issues that emerged after her fall were resolved in her own home, which helped her to remain at home and aided recovery. The service also includes post 24/14 support with a package of care including up to 4 calls a day.

Helping you to Shop supports residents by providing a service in which the council's in-house Swan Rider bus service and volunteers from its community work place and personal development scheme, **Back2Base**, collect and accompany residents to do their weekly shop. One such local resident is 85 year old Peggy from High Wycombe who has been helped to shop since the scheme was launched last September. Peggy, who uses a walking frame and needs wheelchair access also has restricted eyesight due to macular degeneration said: **“Being able to do my own shopping is wonderful. It has been years since I was able to go myself.”**



An **ASC Care Package** was set up for **Gypsy/Roma/ Traveller communities** member George and his family, after being discharged from hospital. However, when it became obvious that his family were unable to care for George despite the care package, ASC asked the manager of the chosen residential home to visit the family to get a feel for the different culture. George has settled well in a home some distance from his site and the family are prepared to make the journey because they know that his needs are being well met. Part of his care plan is that he is taken outside for some part of every day regardless of the weather (this man was born under a hedge and would never want to stay indoors). ASC also assisted in the process of replacing his wife's old leaking caravan. The positive outcome was enabling George to access service to meet his needs; and in educating others on the needs of his community through sharing knowledge and ensuring an emphatic understanding of diversity.

Time 4 You is a new service that addresses those living alone or in social isolation and who find it difficult to pursue a hobby or pastime. We offer a monthly visit to users in their home, for up to six hours, to give them time to enjoy activities that they might not otherwise be able to do – such as light gardening, painting, playing card games or even just conversation.



Direct Payments has changed the life of Daisy, a 33 year old resident who has cerebral palsy and is a wheelchair user. Previously, Daisy lived in a residential home and as a result of limited freedom and independence, had become very negative about her disability and what she could achieve. Daisy was given the choice of Direct Payments and with the help and support of Adult Social Care, now lives in her own flat aided by 37.5 hours a week from a home carer with whom she has developed confidence and independence. By empowering Daisy to take control of her own decisions and with the support of an outstanding home carer who has worked with Daisy to achieve such tasks as to help clean the house and even wash her own hair, Daisy now leads a more fulfilled and happy life. Says Daisy: **“Living in a residential home made me feel disabled. Having Direct Payments means I can lead a normal independent life, and for the first time, I actually feel normal.”**

All of our achievements have been part of a continuous process of improvement and service modernisation, resulting in better outcomes for users and carers.

But the world does not stand still. We are determined that people will be encouraged to maintain their independence in their local communities.

HOW WE CONTINUE TO MODERNISE SERVICES

We continue to listen to our users, staff and partners. As a result, we are reaching out to the full range of people in Buckinghamshire including those who need good advice so that they can exercise informed choice and control.

This is an extension of our historical investment in prevention, but it also represents a shift in focus. No longer is it good enough to provide services to a minority of people with very high level needs – we must now endeavour to reach a much wider group of people, providing advice and early intervention designed to promote independence, health and well-being. This includes people who fund their own care.

We are also investing in mechanisms to ensure that we hear the voice of users. Examples include:

- Developing a focal point for users in an independent living centre
- Supporting the development of a user group so that views of users of our services are represented
- Ensuring that users are invited to be part of important decision making forums such as partnership boards, steering groups and interview panels.



So what does this mean ..?

Firstly, we need to wisely invest in early intervention services that promote the independence, health and wellbeing of the whole community.

Secondly, we recognise that reaching a greater number of people is not something that we can do alone and that our partnerships with the third sector, private sector providers, health and District Councils are more vital than ever before. Through these partnerships, people can be linked with both universal services (for example, life long learning, culture and leisure) and targeted services, such as keep fit for the over 60s.

THE FUTURE

Where we are going ...

Under the philosophy of **bEAM** we will continue to refocus services, ensuring that those in need of advice and social care are able to access high quality information and services. And we will provide a proportionate response to people eligible for publicly funded social care. We will also provide more assistance to people paying for their own care, helping them to navigate the system and the wide range of choices in the market place.

We will also continue to plan and commission services in a way that reflects the seven outcomes set out in the 2006 White Paper '*Our Health, Our Care, Our Say*'. The services that we provide or arrange should support people to:

- Maximise independence, physical and emotional well-being
- Maximise choice and control
- Maximise dignity and safety
- Live free from discrimination and harassment
- Improve their quality of life
- Make a positive contribution
- Achieve economic well-being

These seven outcomes are absolutely consistent with our **bEAM** philosophy including our responsibilities to support the health and well-being of the whole population of the county.

If we get this right, people will tell us:

- I am as healthy as I can be
- I am able to live a fulfilled life
- I am able to participate as a full and equal member of my community
- I have the same life chances as other adults
- I am living free from discrimination and prejudice
- I have control over my own life and am able to make informed choices
- I feel valued by others

The Challenge ...

Providing personalised care³ and support is also central to how we move forward. The Government has set out a demanding timetable for further modernisation of social care, with an emphasis on all users having a personal budget⁴ by 2012. So building on what we have done in the past, we will see a further shift towards:

- Self-directed support, including direct payments and individual budgets⁵
- Care and support plans that reflect the outcomes that are important to individual users
- A further reduction in the use of traditional institutional care and growth in highly individualised services and support arrangements

The Government is providing a grant of £568K in 2008/09 and more in future years to help with these changes.

And finally ...

Our staff and partners have embraced a huge amount of change in recent years and the pace is unlikely to slacken. The personalisation of social care will provide new opportunities and responsibilities and we will aim to ensure that staff are supported and equipped to respond to these changes.



FOOTNOTES/GLOSSARY

1. Fair Access to Care Services

2. Preventative Services across three tiers are defined within the following 'levels'.

1: These are low-level interventions for relatively healthy people with moderate needs which aim to reduce the number of people requiring services. These services may be delivered by partner agencies, voluntary organisations or other bodies. Examples are Contact the Elderly tea parties, luncheon clubs, community exercise, falls prevention classes and support to carers' organisations.

2: These services focus on people who already have a social or health problem or incapacity which limits their independence, and aim to assist them to return to or maintain maximum independence, and to avoid the need for residential care or hospitalisation. Examples are Intensive Home Care, Shopping Services, Meals on Wheels, Home Alarms, OT aids and adaptations, Time4You, respite care, In-touch and funding carers' services.

3: At this level services are for people who already need high levels of support, and aim to deal with specific problems (like incontinence) so that the person does not require intensive nursing care. Examples are post-stroke rehabilitation and Falls Clinics in residential homes.

(The same service might be offered at all three levels - for example Falls Prevention might be delivered in a community setting such as a leisure centre, in someone's home or to someone in a residential setting recovering from a stroke. Similarly good nutrition will be important for people at a luncheon club, receiving meals on wheels or in a residential home. In each case the aim will be to prevent the person having to move on to the next stage in care.)

3. Local Authority Circular – LAC (DH) 2008 1, entitled Transforming Social Care sets out this new agenda.

4. A personal budget is based on an allocation of social care funding to meet needs.

5. An individual budget can include other streams of funding including supporting people, independent living fund, access to work, in addition to social care budgets.

* Case studies are true stories but the names of residents have been changed to protect anonymity.

Because Every Adult Matters

“Because Every Adult Matters” is the strategic framework for the development of Adult Social Care in Buckinghamshire. It is the County Council’s delivery vehicle for major national frameworks including *“Our Health Our Care Our Say”* and *“Valuing People Now”*. **bEAM** is a progressive approach to the provision of services to the *whole* community bringing a shared philosophy to the planning, commissioning and provision of services by the County Council and its partners.

The programme is set within a business-like environment of

- **Ensuring timely access to services for those who are eligible**
- **Applying the minimum intervention necessary**
- **Safeguarding vulnerable people**
- **Achieving/maintaining independence and control and**
- **Promoting wellbeing**

The philosophy of Because Every Adult Matters was chosen because:

1. It reflects the County Council’s commitment to our most vulnerable adults.

The ASC portfolio will work to ensure that all vulnerable adults living in Buckinghamshire are treated with personal dignity and respect, and be free from discrimination or harassment.

2. Every adult is a potential future user of services.

The ASC portfolio will work to ensure that all individuals are able to exercise choice and control over the support they receive and put in place services which promote independence, recognising that economic well being is a key driver to independence.

3. Every adult will know or be related to someone who uses our services.

The ASC portfolio will work to ensure that local people who are informal carers will receive support that makes their role manageable and less demanding

The ASC portfolio will work to promote the emotional and physical health and well being of vulnerable adults and their carers.

4. Every adult has the potential to support their community through volunteering.

The ASC portfolio will work to ensure that local people have opportunities to make positive contributions to their communities.

5. Every adult can shape how we support local communities through consultation and involvement.

The ASC portfolio will work to ensure that the quality of life for each individual is improved and that this can be achieved through greater community involvement in the planning of the service.

FURTHER INFORMATION

For further information please contact:

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or website at: www.buckscc.gov.uk

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