The vision for people across the system in 2016/17

What we want to achieve by April 2017

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Purpose

The purpose of this paper is to set out in simple terms how we want the 'system' that supports older people, people with long term conditions including disabilities, carers and families to work in future. By the 'system' we mean the NHS, Social Care, District Councils, Housing, Voluntary and Community sector and independent sector organisations providing services for people. This paper prioritises those older people and people with long term conditions who are currently living independently but are vulnerable to becoming frail or needing higher levels of support or intervention in future. This paper is aspirational – it describes where we want to get to in the next year, building on work that is developing across the health and wellbeing system in Cambridgeshire and Peterborough.

We hope that in 12 months' time, implementation of many of these changes will be underway. This paper should form the basis for the Cambridgeshire and Peterborough Better Care Fund Plans for 2016/17 onwards; and builds on the work that has taken place so far and the '10 aspects of an integrated system' that have previously been agreed at the CEPB The narrative set out here should underpin the ethos of the 2016 Vanguard work and all other integrated transformation workstreams going forward for the system as a whole.

Broadly speaking, these changes can be divided into support for people who do not have, or have not yet developed, significant ongoing health needs; and support for those people that have significant ongoing needs and receive support from a range of organisations. To achieve our ultimate aim of a shift away from long term social care or care that is provided in the acute setting to preventative services that are focused on keeping people well, we need to focus on our response across both cohorts

Before people have significant ongoing needs

Healthy ageing and prevention

We are increasingly focused on establishing and implementing approaches that prevent or delay the need for more intensive health (specifically admissions and re-admissions to hospital) and social care services, or, proactively promote the independence of older people and people with disabilities and their engagement with the community. This includes specific and planned evidence based public health programmes with an emphasis on falls, social isolation, malnutrition, dementia and promoting continence. A lot of work is already happening in this area, which should remain a key priority across our organisations into 2016/17 and inform the Proactive and Prevention workstream that has been set up as part of the NHS System Transformation Programme.

Eyes and ears – indicators of vulnerability

We want our staff across the system to be able to act as 'eyes and ears' – spotting indicators that someone is becoming more vulnerable and referring them to appropriate support. This includes not just medical or social care staff but any public sector staff that come into contact with the public.

To support this, we will develop a list of 'triggers' which indicate that someone has, or may develop, increased vulnerability. Examples include someone asking for assistance with their wheeled bin, a request for a personal alarm/life line, a concern raised when a housing provider carries out a routine visit, a death is registered or a blue badge is requested. It will also include medical triggers such as low mood/depression, continence/ frequent UTIs, injuries caused by falls, or frequent missed medical appointments. When these triggers are noticed the system will have a planned response to offer support, advice and information.

Clear and joint sources of information

People will be able to access a consistent library of health, social care and wider information from a number of places - including web sites, a library or community hub or their GP surgery.Information will be available in print or digitally. Consistent and up-to-date digital information will be available, as each source will call on a shared database of information so that organisations offering support only have to update their information in one place – and it is available across all sources. From accessing this information it will be easy for people to find out how to make contact if they need further support.

A real or virtual 'single point of access' for advice and support

Identification of these triggers, or a member of the public making contact, will result in a referral to a co-located or virtual single point of access where advice can be sought. Those who take the call can check existing levels of involvement with our agencies across different information systems via appropriate look-up access to records. There will be joint single point of access based on the assumption that 'there is no wrong door'. This will be based on the different referral points for health, social care and the VCS operating as one virtual front door. Ensuring that once a referrer or patient or carer has entered the system they are effectively directed to the right service quickly and are not aware of potentially moving between providers as part of that navigation process. This will be available for planned and unplanned care therefore ensuring all needs are met effectively.

If a follow-up appointment is needed there will be capacity for health and social care staff to make contact in person if a face to face conversation is needed with the individual or their carer, partner or relative. This could take place in someone's home or in the community.

Holistic identification of need with a coordinated response

Two types of 'assessment' tool will be available to support staff to identify levels of need and easily communicate that to people in other disciplines.

First is a tool that can be used quickly in any setting as a basis for a shared language across sectors when identifying what the level of need is,with a view to deciding what action would be most appropriate. The Rockwood Frailty tool will be used to assess an individual's level of physical frailty. We will investigate whether it would be useful to supplement this with another simple tool that can quickly summarise levels of social and community need

As well as that simple tool, a more in-depth holistic needs assessment tool will be available that could be used to assess the full range of needs (physical, mental, social); and identify what support could prevent further escalation. A virtual 'team around the older person' or MDT would be

established with all involved in this team (e.g. GP, District Nurse, Social Care practitioner, Housing provider, home care agency, local voluntary organisation, neighbour) being able to work to a shared plan based on shared information. A lead professional would be identified for as long as was needed as a key point of contact, to coordinate support and to simplify a complex system for people requiring support. This would most likely be the person who has most contact with the person and as circumstances change, the lead professional may also change. The purpose of this team would be to support the person and put measures in place which improve outcomes and avoid, as far as possible, escalation of need and admission to hospital or nursing/ residential care.

Support for people with significant ongoing needs

Clear, coordinated pathways and hand-offs

Services for people with significant ongoing needs will be well coordinated. Our teams will work in a different way with more of a focus on outcomes than process. We will be clear on the whole pathway as an integrated set of providers, and therefore hand offs will be seamless. For example a call may come into JET, yet the best response would be asocial care response/ social care may already be involved. A hand off would take place, with the patient getting the timely response most appropriate to meet their needs and prevent escalation. Our staff will be co-located where possible, and if not will work as a virtual team to ensure there is a seamless joined up and coordinated response.

Neighbourhood teams

Neighbourhood teams will be embedded and operating effectively. Social care staff will be aligned to, or 'vertically integrated' with Neighbourhood Teams to ensure the appropriate person is the key worker/coordinator.

Case finding and case management

A clear understanding of the whole system pathway and robust case finding and case management techniques will help us to anticipate future need and also to wrap integrated services around the patient, preventing them from going into crisis and therefore hospital. In each Neighbourhood Team area work would be undertaken to ensure that there is a shared understanding about the profile of that population and where additional support and intervention is most likely to have benefit.

Working with Care homes

Although our focus is on supporting people to live independently we recognise that residential care is the most appropriate choice for people that need it. We will continue to support care homes to ensure that their residents continue to receive high quality support that is focused on preventing their needs from escalating. We will continue to invest in training for care homes. We will expand older people's CRHT with new resources to support people with dementia and complex needs in care homes. We will prioritise funding for care home placements to ensure that people are supported to live independently as long as possible.

Working with housing providers

Supporting people to live independently requires that they have access to homes that are appropriate to their needs. We will work together with housing agencies to co-ordinate health, housing and social care to ensure that older people have access to accommodation that they want to live in, that enables them to remain independent within their community wherever possible. We

hope that this will help older people to have a choice about where they live, even if their health and social care needs are high or escalating. We will work to explore a range of opportunities linked to use of the Disabled Facilities Grant; and support for equipment and adaptations that enable people to remain at home for longer. People will also have early access to advice on the housing options available to them, to ensure that they can make choices and plan for their future.

Enablers

These arrangements will be supported by the following more general'enablers'. These are activities that will have an impact on success across the whole system, including things such as better use of technology, better use of our assets, having a well-skilled workforce, and better relationships with communities and the voluntary sector. We will focus on:

Information and data sharing

Provision of the best quality and most appropriate services to adults in need of help and support can only be delivered if agencies have access to the correct information about service users' individual circumstances. We will work to ensure that practitioners have the data that they need to make the best possible decisions about people's care; to develop preventative strategies, and to ensure that patients do not have to tell their story to all of the different agencies involved in delivery of their care and support. We will work to ensure that professionals in one organisation can access information that is held by others – with appropriate consent in place.

A common language

By January 2017, we will have established a common language that will give us theassurance we are able to work effectively and efficiently as a whole system, this will ensure that our well defined pathways can be navigated by any provider or user of the system.

Workforce development

Greater integration means new ways of working across the whole system; and everyone working in all of our organisations will need to think differently about their role. Staff will need to develop new skills and work across traditional boundaries.. Common approaches to training and development, as well as a common language across services, will be needed to achieve the full benefits of integration. We will have developed jointly managed teams as well as very close links at the NT level so our inclusion of the system as a whole will have changed in approach.

Property co-location

Where possible, we want staff from across the system to be co-located or able to shareworking space in a variety of settings. As partner organisations move towards more mobile working and reduced office space, there will need to be a better join up in relation to planning use of estates to achieve vertical or functional integration. In addition it will be important to make use of existing assets such as libraries and other community buildings to act as a point of information and advice. We will use technology to help us work more closely where we cannot be co-located and for such services as the SPA this will be essential.

Joint commissioning of the voluntary and community sector

Service transformation approaches across both health and social care are increasingly focused on early help and linking people into services commissioned through the voluntary sector. Co-ordinating support for people who do not yet meet the threshold for statutory services or formal interventions will be key to reducing admissions. Many of these services and interventions are provided by Voluntary and Community Sector (VCS) organisations. VCS provision is therefore becoming increasingly valuable and all commissioners are looking to work more closely with the VCS.

Joint commissioning could allow greater coordination of such services, which have benefits across the health and wellbeing system.

Specific priorities

The specific components of this model that we will focus on are:

Prevention

- An explicit prevention programme with an emphasis on falls, dementia and promoting continence; and on improving outcomes for people with long term conditions
- A joint set of standards for information making consistent information and advice available from a variety of different sources
- 'Eyes and ears' - a clear agreement about what the triggers for support should be and how the system will work

Joint planning and commissioning

- A joint approach to commissioning the voluntary and community sector between the CCG and local authorities
- Reviewing our approach to housing adaptations and the Disabled Facilities Grant to ensure they are supporting as many people as possible to live independently
- Joint risk stratification of the population to inform Neighbourhood Team working
- Joint approach to the commissioning of beds and accommodation across the CCG area

Neighbourhood Team working/Local team around the person

- Aligned social care and community health staff
- Co-location at every opportunity
- The Rockwood tool used to quickly assess physical frailty; and investigation of alternatives for social and cultural needs
- Information sharing – with staff able to access data held in different systems
- A joint needs assessment tool- information gathered from range of sources and outcome of assessment shared based on consent
- Lead professional identified where needed to avoid escalation
- Joint work force development programme for all staff working in this way

Integrated pathways

- Front doors operating as if one
- An integrated pathway for the intermediate tier
- Delegated tasks and trusted assessor approach- carrying out tasks on behalf of each other within clear accountability framework
- Joint approach to care homes prioritising investment in training to prevent residents' needs from escalating