Agenda Item No: 7

PROGRESS REPORT ON HEALTH & WELL-BEING STRATEGY PRIORITY 2: SUPPORT OLDER PEOPLE TO BE INDEPENDENT, SAFE AND WELL

To: Health and Wellbeing Board

Date: 2nd July 2015

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1.0 PURPOSE

1.1 The purpose of this report is to update members on progress with the Health & Well-Being (HWB) Strategy Priority 2: Support Older People to be independent, safe and well.

2.0 BACKGROUND

2.1 Background information is provided in the associated HWB themed meeting template, which is attached as an appendix to this paper.

3.0 SUPPORTING PARAGRAPHS

3.1 Aims set out in Priority 2

For ease of reference, the aims set out in Priority 2 were as follows:

Interventions which reduce unnecessary hospital admissions for people with long term conditions, enable them to live independently at home or in a community setting where appropriate and improve their health and wellbeing outcomes e.g. through falls prevention, stroke and cardiac rehabilitation, supporting voluntary organisations and informal carers.

Integrate services for frail older people and ensure that we have strong community health, housing, voluntary support and social care services tailored to the individual needs of older people, which enable them to improve their quality of life and minimise the need for long stays in hospitals, care homes or other institutional care.

Enhance services for the early prevention, intervention and treatment of mental health problems in older people, including timely diagnosis and joined up services for the care and support of older people with dementia and their carers.

Ensure appropriate and person-centred end of life care for residents and their families and informal carers.

There are two main elements which the CCG, Local Authorities and other stakeholders are pursuing to deliver on the HWB Strategy Priority 2 aims: firstly the Older People & Adult Community Services Contract with UnitingCare, which launched on 1st April 2015, and secondly the Better Care Fund (BCF). The Better Care Fund is covered elsewhere on the agenda, but is referenced briefly here for completeness. These elements also form part of

the Joint Older People Strategy (approved as an Annex to the HWB Strategy), and contribute to the Cambridgeshire & Peterborough System Transformation Programme. The Cambridgeshire Executive Partnership Board (CEPB) is ensuring that there is coordination across the various components.

3.2 Older People & Adult Community Services Contract & UnitingCare

Introduction

Working in partnership with stakeholder and partner organisations, the CCG has embarked on an ambitious programme of transforming Older People's and Adult Community Services (OPACS). The vision for integrated older people's services and adult community services is set out below and is designed to support the HWB strategy aims:

- For older people to be proactively supported to maintain their health, well-being and independence for as long as possible, receiving care in their home and local community wherever possible
- For care to be provided in an integrated way with services organised around the patient
- To ensure that services are designed and implemented locally, building on best practice
- To provide the right contractual and financial incentives for good care and outcomes
- To work with patients and representative groups to design how we commission services.

The main components of the OPACS contract are:

- An innovative framework for improving outcomes which goes beyond traditional organisational boundaries
- A new contracting approach which combines a capitated budget with Payment By Outcomes to enable a population approach to service delivery, align incentives in a better way than current funding mechanisms allow, in a way which is consistent with the CCG's long term financial plan
- A 5 + 2 year contract term to enable investment and transformation
- A lead provider, UnitingCare, responsible for the whole pathway, providing leadership and operational coordination.

Taken together these elements are intended to deliver cultural, service and structural transformation.

In November 2014, at the end of a two stage competitive dialogue procurement exercise, UnitingCare were appointed as the Lead Provider of Older People's and Adult Community Services in the Cambridgeshire and Peterborough area. UnitingCare is a new, joint partnership of two NHS organisations:

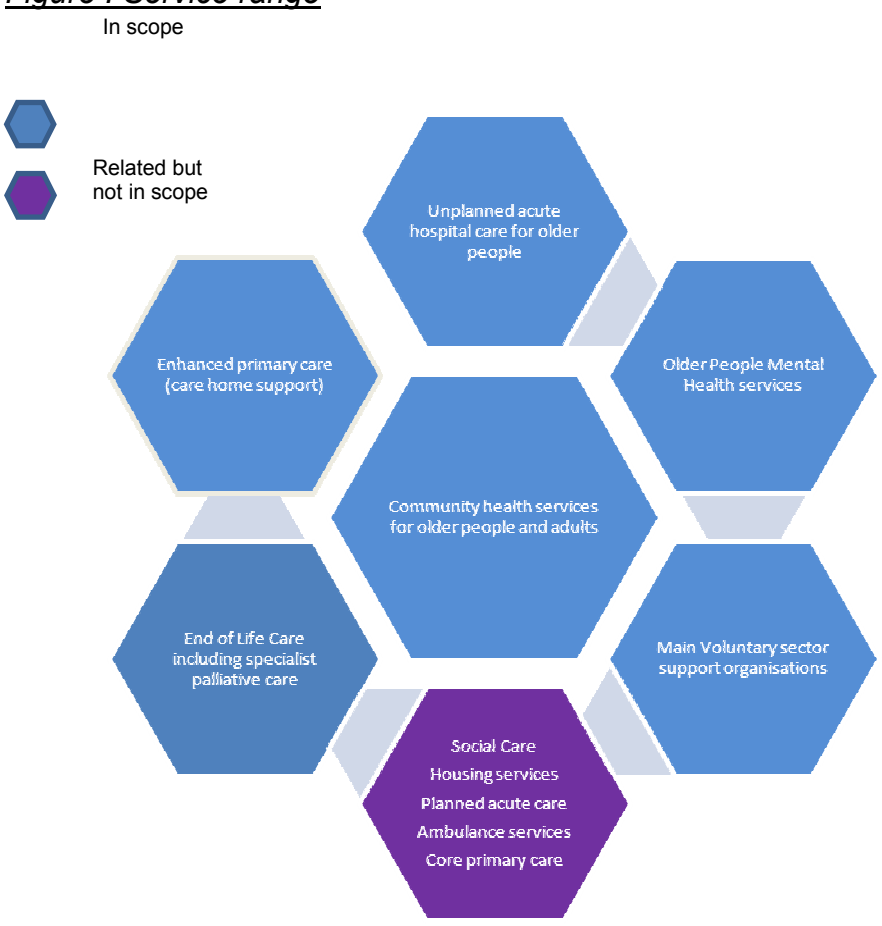
- Cambridgeshire and Peterborough NHS Foundation Trust: a local provider of integrated community, mental health, learning disability and social care services
- Cambridge University Hospitals NHS Foundation Trust: a regional hospital delivering care through Addenbrooke's and the Rosie hospitals.

UnitingCare's role is to integrate Older People and Adult Community Services in Cambridgeshire and Peterborough, in conjunction with UnitingCare partners, to ensure that care is joined up around the needs of the people served. The new service started on 1st April 2015. The transformation of the services will gradually progress with much of UnitingCare's new model of service delivery in place by October 2015.

Services in Scope

The core scope of services is acute unplanned hospital care for older people (65 and over), older people's mental health services and older people and adult community services. The entire range of services relevant to the care of older people is shown in the figure below : Service range. The underlying principle is to create an integrated care pathway between all of these services.

Figure : Service range



Whilst the full range of social care and funding is not in scope, the CCG is working closely with Local Authority (LA) partners on the wider Programme. Cambridgeshire County Council, Peterborough City Council and District Council representatives have been integrally involved in steering the programme, and are building strong links with UnitingCare as they establish their service model. There is a strong alignment and synergy between the OPACS work and the aims of the Better Care Fund which will enable and support it. The

CEPB has an important role to play through its oversight of the BCF projects in ensuring that the UnitingCare model is closely integrated with those parts of the health and wellbeing system that are not in the scope of the contract.

The New Model of Older People and Adult Community Care Services

The priority for UnitingCare on 1st April 2015 was to ensure a safe transfer of existing services. The following key features of the UnitingCare care model are now being phased in across Cambridgeshire and Peterborough:

- ***Integrated teams***: 17 neighbourhood teams across Cambridgeshire and Peterborough. Each team will support up to six GP practices, and will provide community-based healthcare centred around the patient. These teams will each include a combination of community nurses, psychiatric nurses, allied health professionals, and support workers, all working together providing planned and rapid response services to meet the needs of the patient. Neighbourhood teams will be supported by specialist health care professionals in four integrated care teams, based in Huntingdon, Peterborough, Cambridge and Fenland/Ely. These teams will include a housing co-ordinator to ensure any accommodation issues are addressed, alongside consultants, geriatricians, psychiatrists, cardiologists, respiratory physicians and palliative care consultants for advice and consultation. The configuration of the Neighbourhood Teams has been developed, engagement with staff is underway leading to consultation with staff and implementation of new arrangements from September 2015.

- ***OneCall - UnitingCare single point of co-ordination***: the new OneCall Service was launched on 6th May 2015, taking referrals from GPs in its first phase. The aim is that services will be accessible via a single telephone number available to GPs, out of hours services, community and mental health teams, hospitals, social care teams, voluntary organisations, residential care homes as well as patients and carers. Staffed by professionals with access to expert clinical advice, it will provide people with guidance and advice as well as signposting them to relevant services or support.
  UnitingCare will work with GPs and their teams to identify the patients at greatest risk of deterioration or future hospital admission and then co-ordinate their care through regular reviews by a multidisciplinary team comprising health, social care and housing support professionals.

- ***Joint Emergency Team (JET)*:** the new JET service was launched on 6th May 2015, taking referrals from GPs and operating during daytime hours only in its first phase. It is being rolled out as a 24/7 emergency service that will work alongside ambulances and out of hours GPs to undertake assessments and provide immediate treatment or care in the patients home, preventing unnecessary referrals to hospital and allowing more people to receive care in the comfort of their own home.

- ***Wellbeing and prevention***: UnitingCare will work closely with voluntary organisations and social care to deliver services and support for adults and older people to help keep people well.

- ***Technology*****:** Currently different organisations use different electronic patient record systems, which means for example GPs cannot see what hospital staff have added and vice-versa. The new technology will bring together summaries of all the different records for that one patient, creating a single view of the whole patient record. This will speed up some of the processes making it easier to make decisions. It will also enable patients to view their own records. The first phase will be the launch of a 'single view of the patient record' in July 2015.

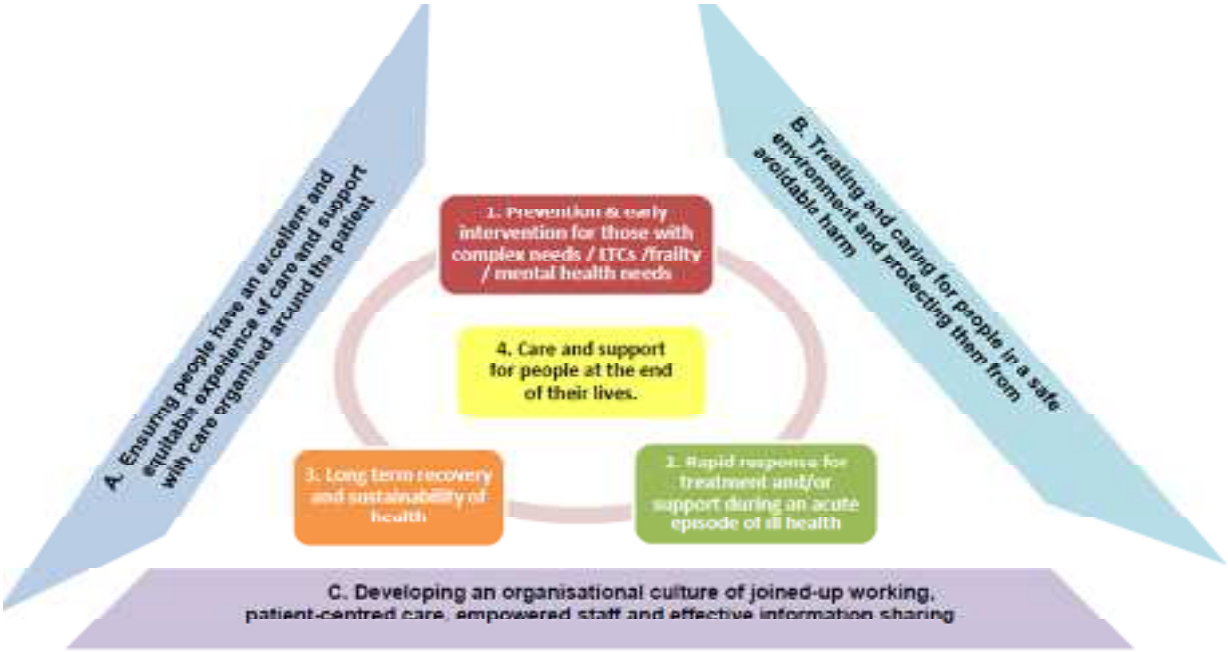
Outcomes Framework

The CCG wishes to support transformation and investment in community services and is using a new funding and payment approach focused on outcomes. The CCG has developed an Outcomes Framework based on seven domains and this will form the basis for service specifications to drive improvement in quality and outcomes. A set percentage of the value of the Contract will be paid on achievement of the Outcomes Framework Indicators, which are designed as markers of a high quality, improved service which is financially sustainable.

The Outcomes Framework Indicators are derived nationally and from evidence based quality standards, local data sources, national guidance and research on patient experience and the expert perspective of Public Health, clinical leads and patients from the local population.

The Outcomes Framework covers seven outcome domains as shown below.

Figure : Outcomes Framework Domains



In each domain there are a number of specific outcomes with indicators underpinned by technical specifications. The CCG and UnitingCare are now in the process of implementing the Outcomes Framework which involves capturing some existing and some new information. A programme of further stakeholder engagement in the next stages of development is being planned, including patient / public involvement in work on the 'domains'. This will link to a refresh of the Joint Older People Strategy, which was originally completed in advance of the letting of the OPACS contract, to more fully reflect recent service developments across the health and wellbeing system.

Transformation of social care services

Whilst social care is not included within the scope of the OPACS contract, the County Council is overseeing the implementation of *Transforming Lives,* a new strategic approach to social work and social care for adults in Cambridgeshire. It is an ambitious change programme which presents an opportunity to develop a model of adult social work and social care which is markedly different from the current model in Cambridgeshire. We are seeking to develop an approach that is increasingly proactive, preventative and personalised and will enable the residents of Cambridgeshire to exert choice and control and ultimately continue to live healthy, fulfilled, socially engaged and independent lives, to the fullest extent possible. This new way of working will embed social care staff in local communities, playing a strong role in multi-disciplinary teams alongside health and voluntary sector colleagues.

The new model is based on 3 levels of intervention: Help to Help Yourself; Help When You Need It; and On-going Support.

Help to Help Yourself: Information, advice, prevention, early identification and early intervention are inextricably linked. Information and advice would help people to find out about local voluntary and community activities and the model will include the concept of 'supported introductions' to activities where people are reticent to attend alone. Strong, independent communities and supportive families and carers are crucial to the success of this model. Families and carers are often best placed to support individuals to achieve their aspirations.

Help When You Need It: Crisis resolution provides a local, rapid response immediately following a crisis, at which the individual is put at the centre of this intensive work. It focuses on the needs of the individual at that point in time, and very short term planning will take place with support designed around the needs and circumstances of the individual. The adult social care professional would then provide support to the individual for the duration of the crisis, checking with them regularly to ensure that they are coping and feel well supported. The aim of the rapid response is to support individuals through crisis to help them to maintain their independence, prevent further deterioration and the need for longer term adult social care. One of the key aims of crisis resolution is therefore to support people to remain independent of statutory services. Alongside crisis response are reablement, visual impairment and occupational therapy rehabilitation, assistive technology and deaf services equipment, which play a fundamental role in supporting, encouraging and enabling individuals to regain their independence. Where possible, they will be able to continue to live active, fulfilled lives independently in their own homes and maintain their role within the local community. This model suggests that an increased investment in professionals to assess for Assistive Technology and the technology itself which could prevent or delay access to more costly and longer term social care packages.

On-going Support: The longer term support for individuals would be planned through the use of holistic, integrated assessments, and would be self-directed, based upon personal budgets and the principle of choice and control. The nature of the strengths based conversations that professionals will have with the individual would change. Planning would take place with the individual to ensure that we are continually building upon their strengths, families, networks and resources to achieve their aims. At this level, it is anticipated that deeper conversations may be required, for example into individual's personal financial circumstances. It will be acknowledged that the individual, their carers and their families are the experts on their own lives. Individuals in receipt of on-going support from adult social care services would be encouraged to utilise assistive technology and rehabilitation services and encouraged to be active participants within their local community. Should any additional issues be raised, the individual would be signposted to information and advice, enabling them to find a local solution that meets their needs.

Both the OPACS contract and Transforming Lives have broadly the same aim - to shift investment across the health and wellbeing system from acute, hospital-based services and long-term social care, towards greater investment in preventative services to support people to stay independent for longer and receive greater support from within their communities. However, with services being delivered across a range of different organisations, there was a danger that these initiatives, if taken forward separately, may not have created an integrated system, but rather reinforced silo working and created a range of unintended consequences for people

To address this, a paper was developed and shared widely across the system titled 'Developing an integrated system for Cambridgeshire to improve outcomes for older people'. The paper proposes a set of practical proposals for implementation, that would move us towards a more integrated system. These features are:

1. A series of community based programmes and support that help people to age healthily
2. A recognised set of triggers of vulnerability which generate a planned response across the system
3. A universal network helping older people and their families to find high quality information and advice
4. An aligned set of outcomes
5. An integrated front door with an agreed principle of 'no wrong door'
6. Shared assessment process, information sharing between health, social care and other key partners
7. A shared tool that describes levels of vulnerability
8. A locality based Multidisciplinary team approach (MDT)
9. Co-located staff
10. Joint commissioning and aligned financial incentives

These proposals have been placed at the heart of Better Care Fund proposals in Cambridgeshire and Peterborough, and have formed the basis for the BCF integration projects being overseen by the CEPB.

The Better Care Fund

The five Better Care Fund projects will form an important element of delivering Priority 2 aims. These are set out very briefly here for reference, noting that the detail on each one is set out in a separate update paper on the agenda.

Data Sharing – aims to deliver an effective and secure joint approach to data sharing across the whole system, enabling improved co-ordination and integration of services for adults and older people.

Seven Day Working - aims to expand 7 day working to ensure that discharge planning is undertaken according to patient need, not organisational availability.

Person-Centred System: aims to ensure that care and support are planned and co-ordinated by primary multi-disciplinary teams of professionals working closely with primary care agencies particularly focussing upon people identified as at risk of becoming frail or requiring hospital admission in the future.

Information and Communication: aims to develop and deliver high quality sources of information and advice based on the individual needs of the population, not on organisational boundaries.

Ageing healthily and Prevention: aims to develop community-based preventative services to support and enable older people in particular to enjoy long and healthy lives, to feel safe within their communities, thus promoting independence and preventing people from requiring long-term health and social care needs. For the purposes of this programme of work, preventive services are defined as those that prevent or delay the need for more intensive health and social care services, or, proactively promote the independence of older people and engagement with the community. Potential focus areas include falls, mental health & dementia; physical activity & nutrition; incontinence and UTI's; multimorbidity; social isolation, loneliness and bereavement.

These projects will be implemented from April 2015 onwards. BCF plans also commit to reducing non elective admissions by 1% by Q3 in 15/16.

Long Term Conditions JSNA

The LTC JSNA is due for presentation at the HWB on the 2nd of July 2015 and is relevant to priorities 2 and 3 of the Health and Wellbeing Strategy 2012-17:

- Priority 2: Support older people to be independent, safe and well
- Priority 3: Encourage healthy lifestyles and behaviours in all actions and activities while respecting people's personal choices

The JSNA focuses on people with adult-onset LTCs at high risk of poor health outcomes. This higher risk group has been identified as a group where preventative interventions hold the greatest potential to improve outcomes and reduce burdens on health and social care services.

The JSNA provides background, evidence and methods to identify those whose needs are such that they are vulnerable to poorer outcomes and requiring additional support from health or social care (specifically admission to hospital or care facility) as well as data describing this population at a local level. A review of the evidence base is also presented which highlights national guidance and recommendations and effective interventions in response to identified needs of the population with LTCs at risk of poorer outcomes. As

prioritised by stakeholders and supported by the literature; relevant cross-cutting themes were examined in greater detail to aid identification of a higher risk LTC population: multi-morbidity, limitation, pain, health inequalities, mental health and emotional wellbeing. A range of models of care were examined to identify solutions that could applied to the local Cambridgeshire high risk LTC population.

The approach to LTCs within this JSNA is in alignment with emerging approaches to LTCs and models of care which move away from single disease models. This approach is in keeping and responds to demographic change and current pressures on health and social care resources. The process and production of the JSNA is timely as new structures and service design models are currently in effect across the County and for which this piece of work will provide a base and foundation for further work across several local priority areas.

Together with the previously published Primary Prevention JSNA, an approach to prevention across the lifecourse, with a particular focus on LTCs older people, is provided.

4.0 ALIGNMENT WITH THE CAMBRIDGESHIRE HEALTH AND WELLBEING STRATEGY

4.1 If relevant, a reference to the alignment with the Cambridgeshire Health and Wellbeing Strategy (link to Strategy http://tinyurl.com/ccch-wstrat). This is an update on Priority 2 of the HWB strategy.

5.0 IMPLICATIONS

5.1 This is an update paper for members, so there are no new proposals contained within it.

6.0 RECOMMENDATION/DECISION REQUIRED

6.1 Members are asked to note this update.

Source Documents	Location
Further information on the CCG Older People Programme and Outcomes Framework	http://www.cambridgeshireandpeterboroughccg.nhs.uk/pages/older-peoples-programme.htm
Further information on UnitingCare	http://www.unitingcare.co.uk
Further information on the Better Care Fund	http://www.cambridgeshire.gov.uk/info/20166/working_together/575/better_care_fund